



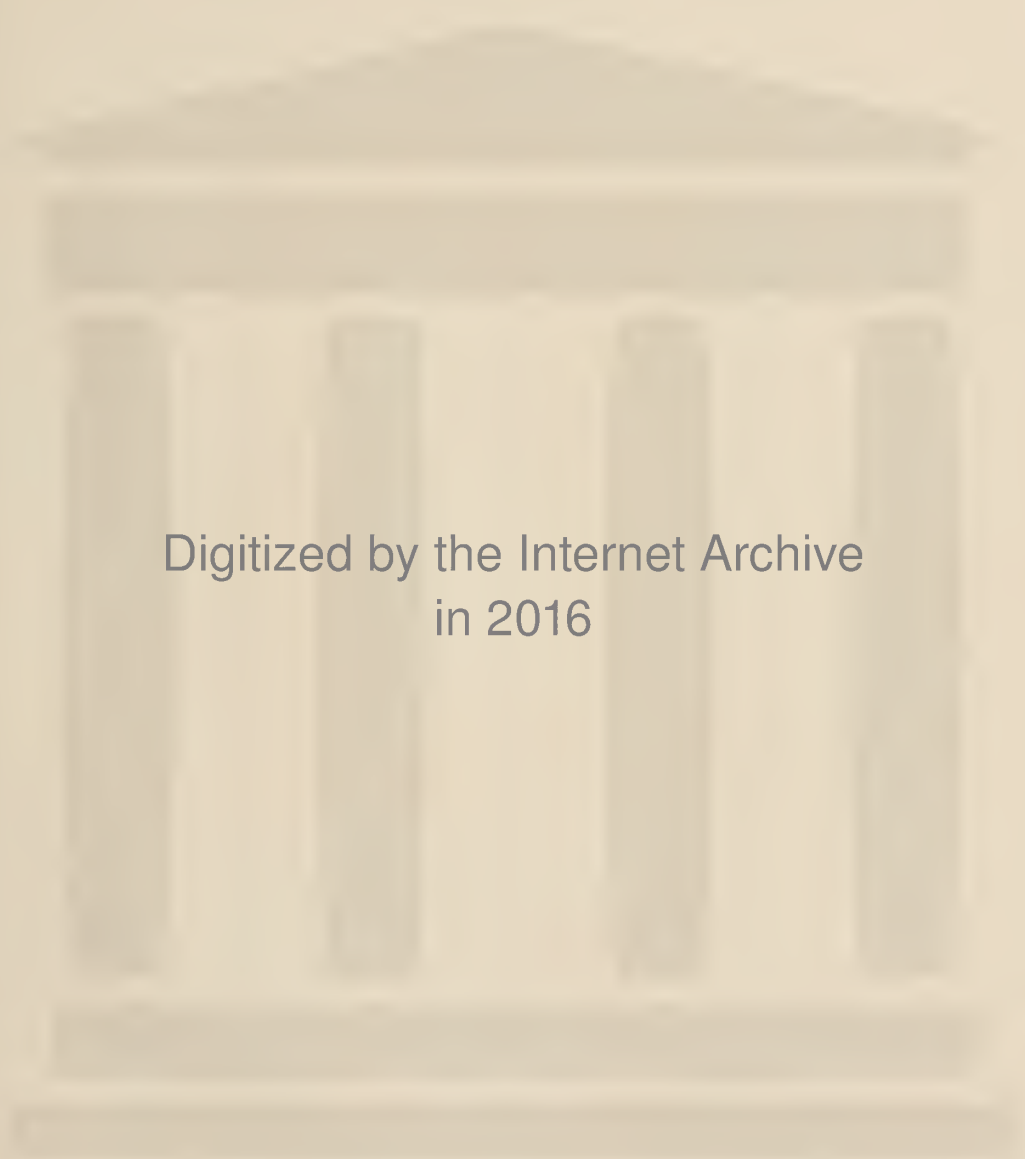
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July 1977

Journal of  
the Medical  
Society of

# New Jersey

Governor's Conference

Transactions  
1977 House of Delegates

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# Blue Shield to drop 28 plan procedures

CHICAGO (Reuters) — The Blue Shield Association, the nation's largest health insurance group, yesterday said it was ending routine coverage for a variety of medical procedures deemed largely unnecessary.

Included in Blue Shield's new Medical Necessity Program (MNP) are 18 surgical and 10 diagnostic procedures which together cost the company more than \$27 million in 1975.

Blue Shield, which reimburses physicians for care provided to some 36 million persons covered by Blue Shield plans, will pay for such procedures only if the performing physician can justify them in writing.

William Ryan, Blue Shield president, told a press conference MNP was aimed at helping stem the rising cost of health care and saving money for Blue Shield subscribers.

A Blue Shield spokesman said subscribers could not expect lower premiums or rebates, but the rate of increase in premiums might be slowed by MNP.

Ryan said that in setting up the MNP, Blue Shield was assisted by the American College of Physicians, the American College of Radiology and the American College of Surgeons.

He said the 28 procedures either were of questionable value, were redundant when performed along with other procedures, or were unlikely to provide physicians with necessary additional information when performed more than once.

However, he told newsmen "if there is a clear need for any of the procedures, Blue Shield will pay for them. The point of this program is to encourage medical professionals to think about the costs of the procedures they order."

The MNP also covers two surgical procedures for which Blue Shield has never paid claims and will be expanded to cover other procedures after further study, Ryan said.

The plan will go into effect after it has been explained to physicians and subscribers over the next several months.

A spokeswoman for New Jersey Blue Shield said the state plan had been researching a similar program just for New Jersey, but she did not have figures on how many such procedures are done in this state each year.

The techniques include surgical and diagnostic tests which are no longer considered of any value or have been replaced by better methods. Others are procedures which have no proven worth and diagnostic tests which yield little new information.

Examples, she said, are surgery on the carotid artery in the neck as treatment for asthma and surgery on certain sympathetic nerves as a treatment for high blood pressure.

Two diagnostic tests, one fairly common, the basal metabolism rate (BMR), a test for an overactive thyroid gland, and the protein bound iodine test to measure circulating thyroid hormones, also are on the no payment list.

She said New Jersey Blue Shield plans an extensive communications campaign to educate physicians about the program, and then will set a cutoff date after which physicians will need prior authorization to get paid for any of the 28 procedures.

A local physician review panel will be set up to settle any disputes.

## Blue Shield Plans to Curtail Payments For Procedures Considered Ineffective

New York Times Staff Reporter

CHICAGO — Blue Shield intends to discourage physicians from performing what are deemed obsolete or ineffective operations and diagnostic tests as a way to check runaway medical costs.

At least one of the affected 28 procedures, which cost the nation's 72 million Blue Shield subscribers \$27.4 million annually, has been out of favor among surgeons for 50 years.

The so-called Medical Necessity Program was announced at a press conference here by the Blue Shield Association, a trade group, and representatives from three medical specialty groups: Parallel with Blue Cross, which provides hospitalization insurance, the 70 U.S. Blue Shield plans spend more than \$1 billion a year reimbursing doctors for medical and surgical care.

Blue Shield won't pay doctors for any of the 28 procedures unless they justify their need in writing, explained William E. Ryan, Blue Shield Association president. He noted that not all of the \$27.4 million will be paid and passed on to subscribers in the form of smaller rate increases.

But the savings will be substantial, Mr. Ryan said. "And this first step to identify and eliminate unnecessary procedures could become one of the most effective ways to limit future increases in health care expenditures."

The 28 procedures involve 18 types of surgery for such ailments as hemorrhoids, asthma, lower back pain and high blood pressure. Ten diagnostic tests on Blue Shield's no-payment list include ones for jaundice, overactive thyroid glands and limited heart X-rays.

To devise the program, the Blue Shield Association studied the medical records of its 7.5 million federal employee subscribers. The group found, for instance, that it pays about \$1.9 million a year for uterine suspension operations. This kind of surgery, "was formed to relieve lower back pain," was highly popular early in the 20th Century, but has been considered fairly useless since.

Dr. C. Rollins Haslam, director of the American College of Surgeons, said the problem with two of the diagnostic procedures, all involving heart X-rays, is that they were said to provide a picture that they were going to miss the diagnosis, "you're going to miss the diagnosis," said Dr. Richard Allyn, a regent for the American College of Physicians. Other diagnostic tests on the list represent "primarily tired technologies that are being

retired," said Dr. Fredric D. Lake, president of the American College of Radiology. Some reporters questioned the Blue Shield and medical officials as to why the list omits new procedures with unproven effectiveness, such as coronary bypass surgery and CAT scanning, a form of computerized X-rays. Because they're "too controversial," replied Dr. Allyn. "To get (physician) acceptance, we had to first take the ones that are generally recognized as the ones that are generally recognized as outdated."

Mr. Ryan said that the no-payment list is "by no means exhaustive," and that it will be expanded to cover new procedures with unproven effectiveness as well as other medical specialties. Mr. Ryan estimated that it would take several months for the 70 Blue Shield plans to inform and educate their local physicians that they intend to discontinue routine payment for the 28 procedures.

Another reporter asked if the Blue Shield effort was designed to head off President Carter's proposed 9% ceiling on most hospital revenue increases next year. The Blue Shield program might show, Mr. Ryan conceded, that the private sector can move faster to control health costs than government.

## Blue Shield Acts to Curb Payment On Procedures of Doubtful Value

By JANE E. BRODY

The national Blue Shield Association recommended yesterday that its individual plans stop routine payments for 28 surgical and diagnostic procedures considered outmoded or unnecessary, but that currently cost subscribers \$27.4 million a year.

The list of procedures, which includes the basal metabolic rate, extensive surgery for hemorrhoids, and removal of the adrenal gland, was compiled by consultants with leading medical specialty organizations to assure that all procedures done on Blue Shield subscribers are "medically necessary" and in keeping with "quality medical care," a Blue Shield spokesman said.

In eliminating certain procedures for reimbursement, the nation's largest health insurance carrier feels that it will in effect rapidly upgrade the quality of medical care in many parts of the country.

The new payment schedules will be adopted in whole or in part by Blue Shield plans throughout the country after local physicians are informed of the changes. It is up to each plan to decide whether to accept the recommended changes. The new schedules will apply to all present and future Blue Shield contracts.

As a result of physician education, the changes are expected to spill over to non-subscribers, who last year paid \$58 million for these procedures.

In addition, Blue Cross plans are studying the Blue Shield proposal and meeting with hospitals and other medical care providers to work out a similar revised payment schedule, a Blue Cross spokesman said. He added that some plans might mean routine payments for procedures on the Blue Shield list, explaining that "some of these procedures are not considered unnecessary in certain parts of the country."

The Blue Shield list was devised in consultation with the American College of Physicians, the American College of Radiology, the American College of Surgeons and the American Hospital Association. The American College of Surgeons and the Blue Cross Association were also involved.

Blue Shield said that the procedures on the list were either new and of unproven value, established but of questionable value, or redundant when performed in combination with other procedures or unlikely to give the doctor additional information.

If a procedure is outmoded, it means there are better procedures available with better outcomes, the Blue Shield spokesman said. "We want to make sure that the most effective procedure is performed," which would increase the benefit-to-risk ratio.

The organization said that once the new schedules took effect, patients would be reimbursed for the listed procedures only if their doctors submitted written justification of their medical necessity. The documentation would have to be approved by a review panel of physicians before the patient could be reimbursed.

The spokesman said that this reason for payment schedules "was in accordance with the Blue Shield contract, which states that the organization will not pay for procedures that are not medically necessary."

The surgical procedures on the Blue Shield list are as follows: Removal of carotid body tumors, two methods of interrupting portions of the sympathetic nerves in the back to treat hypertension, radical surgery to remove a floating kidney, tying of the mammary arteries in the chest, fastening a tissue from the stomach to other organs to establish better blood flow through the liver, surgical removal of a fatty or fibrous structure covering the sheath of the adrenal glands, circumcision of the female urethra, removal of the uterus through the vagina for non-obstetrical reasons, removal of the uterus but not the cervix, removing the uterus by the uterine tube, or suspending the uterus without fixing or suspending the uterus in one vagina or the nerve pathways in one area.

Also, removal of part of the hypogastric or preauricular nerve, two methods of repairing the sheath of connective tissue binding body structures, and tying the femoral artery for postoperative syndrome.

The diagnostic procedures listed are: Basal metabolic rate and protein bound iodine tests, the icterus index, a test to measure the presence of jaundice, the biliary scintiscan, a measure of the amount of blood in the heart, the phonocardiogram, a test of various heart sounds, four types of angiograms (X-rays) of the heart, and angiography of the arteries of the arms and legs to determine the presence of clots, ruptures or arterial constrictions.

The new procedures listed were fabrications, wrapping of an abdominal aneurysm, extra-intracranial arterial bypass for stroke.

# What is Blue Shield's Medical Necessity Program?

It's a program worked out with the American College of Physicians, the American College of Radiology, the American College of Surgery, and other medical associations to improve the quality of medical care and possibly aid in cost containment. This will be accomplished through ending routine Blue Shield payment for 18 surgical and 10 diagnostic procedures, which are seldom performed, unless the physician can justify their use.

Watch for details in a Physicians' Newsletter on this subject in the near future.



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Founded July 23, 1766



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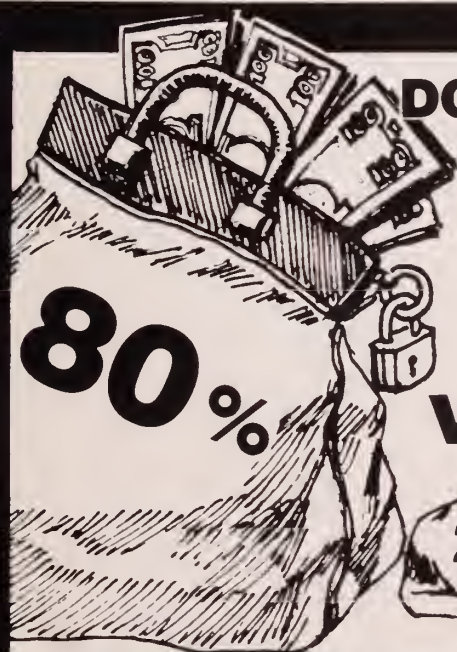
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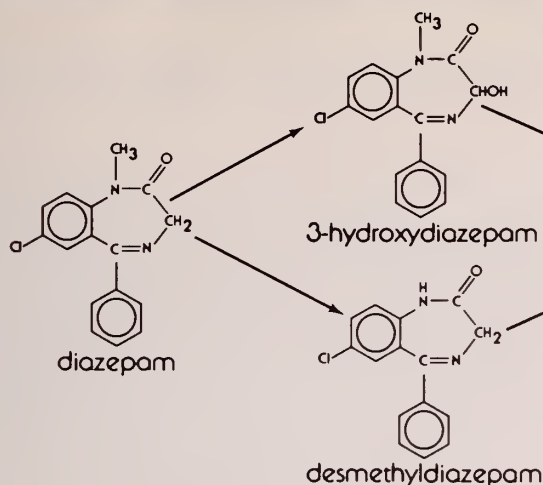
**Warnings:** Not of value in psychotic patients.

Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

**Usage in Pregnancy:** Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.



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WASHINGTON, Aug. 26, 1920—  
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# Social Security Bill Is Signed; Gives Pensions to Aged, Jobless

*Roosevelt Approves Message Intended to Benefit 30,000,  
Persons When States Adopt Cooperating Laws—He Calls  
the Measure 'Cornerstone' of His Economic Program.*

## SENATE APPROVES 18-YEAR OLD VOTE IN ALL ELECTIONS

Amendment to Constitution  
is Sent to House, Where  
Passage is Expected

WASHINGTON, March 10,  
1971—The Senate approved  
today, 94 to 0, and sent to

WASHINGTON, Aug. 14, 1935  
The Social Security Bill, providing  
a broad program of unemployment  
insurance and old age pensions  
and counted upon to benefit  
20,000,000 persons, became law  
today when it was signed by President  
Roosevelt in the presence of  
those chiefly responsible for  
bringing it through Congress.

Mr. Roosevelt called the measure  
"the cornerstone of my economic  
program which is being built to  
meet the needs of the people  
and to bring about a more  
complete recovery of the  
country."

# TRUMAN CLOSES NATIONS CONFERENCE WITH PLEA TO TRANSLATE CHARTER INTO DEEDS

## NEW WORLD HOPE

President Hails 'Great  
Instrument of Peace,'  
Insists It Be Used

## HISTORIC LANDMARK

Meeting Gives Standing  
Ovation as Executive  
Pictures Peace Gain

"If we fail to use it," he declared  
to the solemn final meeting of the  
delegates, "we shall betray all of  
those who have died in order that  
we might meet here in freedom and  
safety to create it."

"If we seek to use it selfishly—for  
the advantage of any one nation or  
any small group of nations—we  
shall be equally guilty of that betrayal."

### Fervent Interpolation

The President, speaking in the  
auditorium of the War Memorial  
Opera House, built in memory of  
sons of the Golden Gate city who  
gave their lives in the first World  
War, in which he himself served,  
seemed to give unconscious expression  
to the solemn feeling of the  
occasion when, at the outset of his  
speech, he interpolated the words,  
half a hope, half a prayer:

"Oh, what a great day this can  
be in history!"

Just before the plenary session  
the President accompanied the  
delegates to the United States Capitol

# the Draft Ends Now

WASHINGTON, Jan. 27,  
1973—"With the signing of  
the peace agreement in  
Paris today, and after receiving a report from the  
Secretary of the Army that





---

# PATIENT PACKAGE INSERTS: A CONCEPT WHOSE TIME HAS COME?

---

*The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely-prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.*

*The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.*

## **The Advantages**

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

Every doctor has had patients who fail to finish antibiotic regimens because they feel better. Some patients assume that if one tranquilizer or analgesic is good, two may be twice as good. Still others fail to report dizziness while on antihypertensive therapy—and so on.

Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

## **The Disadvantages**

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information

is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

## **The Solution**

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.

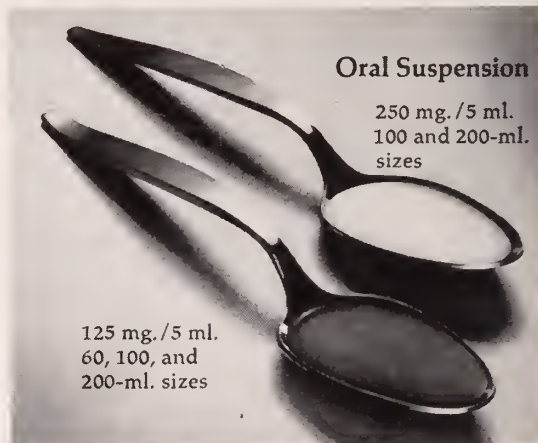
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# EDITORIALS

## Interesting Numbers — Are You One of Them?

- *Five Thousand*—The Medical Inter-Insurance Exchange of New Jersey has enrolled 5,000 physicians licensed to practice medicine and surgery in this state. MIIE is viable, so give it some thought if you are not already one of its members.

- *Six Thousand Five Hundred*—The mandatory Professional Liability assessment, established by the Board of Trustees, has been paid by 6,500 members of MSNJ. If you are one of the 20 percent who has not paid, why not do something about it? Send in your check or, if you feel the assessment is a hardship, ask for special consideration.

- *Two Thousand One Hundred Forty-Seven*—As of the annual meeting, 2,147 of our members were listed as delinquent in their continuing medical education requirements. This figure undoubtedly will be reduced because some members may not have received appropriate AMA credit as yet; failure to send in their CME credit information or the AMA record-keeping system may be at fault. It is striking that 73 percent of the delinquent members were elected to MSNJ prior to 1973 while 40 percent became members prior to 1960.

If you are counted among this group, please act to get your CME credits in order and recorded.

A.K.

## Some Actions of the House of Delegates

The House of Delegates met at the 211th Annual Meeting of the Medical Society of New Jersey to debate and discuss and to act upon the business of the Medical Society brought before it. The members of the House, individually and collectively, took their charge seriously and

enthusiastically. The members of this Society—and all practitioners in New Jersey—owe that body a debt of gratitude.

Some of the positive and negative actions of the House are as follows:

- Adopted proposed Constitution of MSNJ.

- Adopted proposed Bylaws of MSNJ with several amendments.

- Reaffirmed the obligation of all regular dues-paying members, who have not paid the professional liability assessment, to do so unless excused by the Executive Committee after deliberation of individual requests for exemption.

- Rejected the concept that patients be permitted to assign Blue Shield benefits to non-participating physicians because that would be “a disservice to participating physicians of Blue Shield.”

- Rejected the concept of mandatory autopsy in New Jersey as an infringement of privacy and individual rights.

- Directed the Board of Trustees to take steps to oppose the indiscriminate release of gratuitous information in the public press of Medicaid/Medicare fee payments unless such information “has relevance to a specific allegation of abuse, fraud, or unethical practice.”

- Adopted a resolution which opposes the proposed FDA ban on the use of saccharin.

- Adopted a resolution that the New Jersey State Legislature be petitioned “to act immediately, positively, and affirmatively on the Garramone (tort reform) package.”

- Adopted a resolution that a communication be sent to Governor Byrne, the Commissioner of the New Jersey State Department of Health, and to the press, expressing the confidence of MSNJ “in the integrity and capability of Dr. Martin Goldfield,” who recently was demoted from Deputy Commissioner of Health and Director of the Division of Laboratories and



Epidemiology to Director of Research. Dr. Goldfield is a delegate to the House from Burlington County.

Further details of House actions can be found elsewhere in this issue. A.K.

## The Third Annual Governor's Conference

Major speakers from New Jersey and the President of the AMA addressed this Third Annual Governor's Conference dealing with government and medicine. *Plans and predictions*, as well as *attitudes* are the essence of the presentations.

*Governor Brendan T. Byrne*—The Governor listed a number of areas which represent problems in New Jersey. Among these were:

- Cancer in our state
- Recombinant DNA research at Princeton University
- Care of comatose noncognitive patients
- Cost containment and certificate of need
- Professional liability insurance rates
- Statewide immunization
- Health care facilities' financing

The Governor mentioned a need in all of these areas for "input" from the Medical Society of

New Jersey, but there was no guarantee that MSNJ advice will have great weight.

*Richard E. Palmer, M.D., President, AMA*—Dr. Palmer reviewed a number of action programs sponsored or supported by the AMA (see page 607, this issue).

*William C. White, Vice President, Prudential Insurance Company of America*—Speaking about health care financing, Mr. White warned against "socialism through gradualism" (see page 608, this issue).

*Gerald J. Reilly, Acting Deputy Commissioner, New Jersey Department of Human Services*—Mr. Reilly spoke about costs versus professional compensation, regulation, and the partnership between medicine and government. Among his comments were (see pages 611-614 this issue):

"I firmly believe that our current (Medicaid) policy of paying about 50 percent of the usual and customary charge is unsound."

"I also firmly believe that we must include, as a key participant in the exercise of this responsible state role, the voice of the State Medical Society."

"Physicians must be included in the deliberations about governmental health policy."

We must hope that the government representatives were serious about the cooperative spirit and not just giving lip service to this idea.

A.K.

### Cover

The cover portrays an artistic version, prepared from an actual photograph, of members in attendance at a session of the House of Delegates of The Medical Society of New Jersey.

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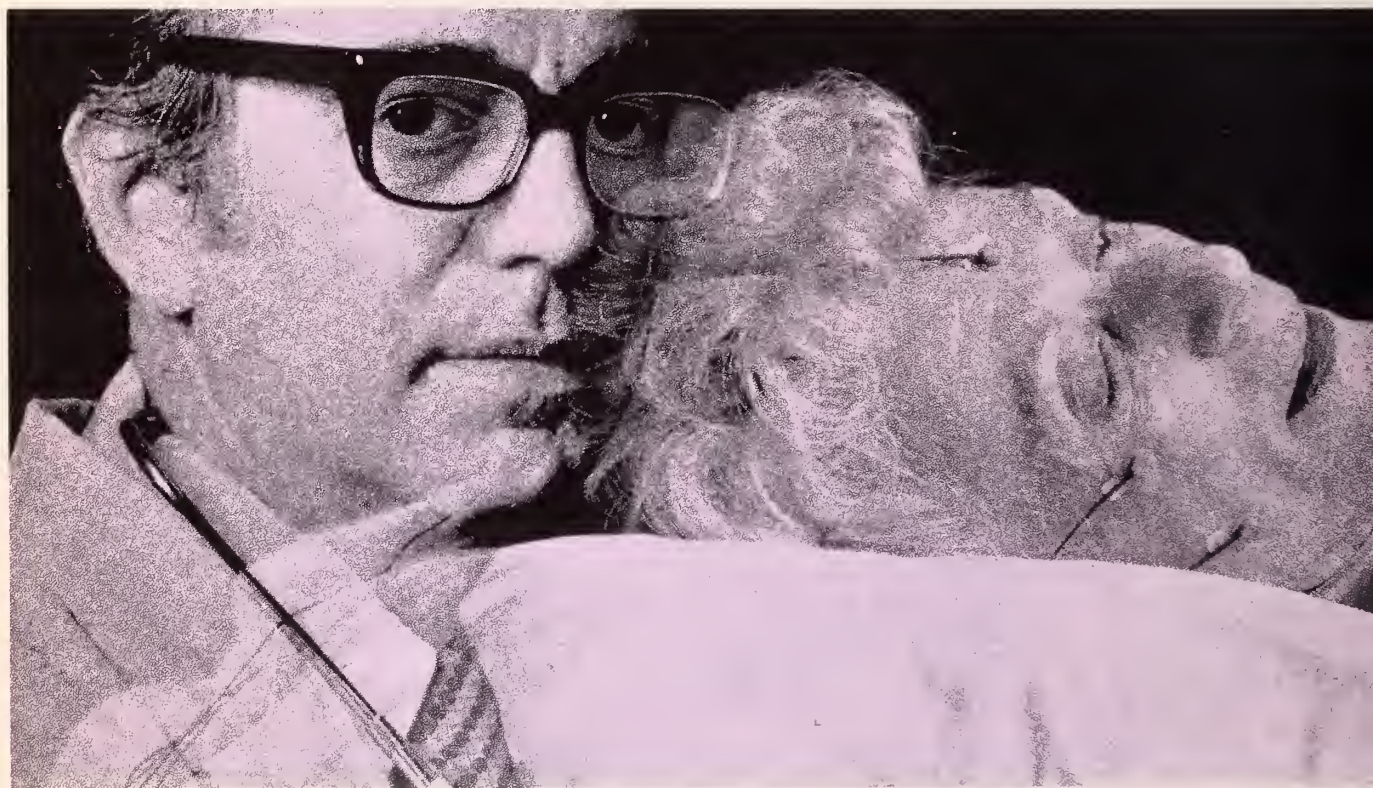
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**Contraindications:** Known hypersensitivity to flurazepam HCl.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

**Usage in Pregnancy:** Several studies of minor tranquilizers (chlordiazepoxide, diazepam, and meprobamate) suggest increased risk of congenital malformations during the first trimester of pregnancy. Dalmane, a benzodiazepine, has not been studied adequately to determine whether it may be associated with such an increased risk. Because use of these drugs is rarely a matter of urgency, their

use during this period should almost always be avoided. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

**Precautions:** In elderly and debilitated, limit initial dosage to 15 mg to preclude oversedation, dizziness and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

**Adverse Reactions:** Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdose, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea,



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**Dosage:** Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients.

*Elderly or debilitated patients:* 15 mg initially until response is determined.

**Supplied:** Capsules containing 15 mg or 30 mg flurazepam HCl.

### References:

1. Kales A, et al: *Arch Gen Psychiatry* 23:226-232, Sep 1970
2. Kales A, Kales JD, Martin ED: *Drug Ther* 5:31-39, Jun 1975
3. Kales A, Kales J: Recent advances in the diagnosis and treatment of sleep disorders, in *Sleep Research and Clinical Practice*, edited by Usdin G. New York, Brunner/Mazel Inc., 1973, p. 61

4. Robinson DS, Amidon EL: Interaction of benzodiazepines with warfarin in man, in *The Benzodiazepines*, edited by Garattini S, Mussini E, Randall LO. New York, Raven Press, 1973, p. 641

5. Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ

6. Young DS, Pestaner LC, Gibberman V: *Clin Chem* 21:110-132D, Apr 1975

7. Moore JD, Weissman L: *J Clin Pharmacol* 16:241-244, May-Jun 1976

8. Spiegel HE: Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ

9. Kaplan SA, et al: *J Pharm Sci* 62:1932-1935, 1973



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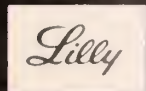
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### What the AMA Is Against ... and For!\*

Richard E. Palmer, M.D.  
President, American Medical Association

I seriously doubt that there is a single person in this hall who does not know what the AMA is *against*.

Certainly our most visible actions of late have been those in the federal courts. Two years ago, we filed suit against the Department of HEW's proposed hospital utilization review regulations. We were vindicated in that suit by the words of the district court judge who gave us a preliminary injunction and stated that the regulations would "delay and unnecessarily complicate medical matters and result in perceptible injury to patients."

More recently, we joined the states of North Carolina and Nebraska in seeking legal relief from the 1974 Health Planning Act approved by Congress. This act, which imposes five, federally dominated and lay-controlled slabs of bureaucracy on health planning, could make a public utility out of American medicine. How can the AMA *avoid* filing suit against an act which tells us—in essence—that while we shall continue to be managers of the medical store, Washington will dictate how many stores will exist, what medical goods and services will be stocked, and how those services will be organized and delivered? The answer is, of course, that we don't have any choice.

The quality of American medicine is the finest in the world, a fact acknowledged even by our most persistent critics. Thus, Senator Edward Kennedy, in the March 19, 1977 edition of the *National Observer*, said:

"Our medical accomplishments are unsurpassed . . . both in the research of our scientists and the clinical excellence of our doctors.

"This growth of medical knowledge is unparalleled in the history of mankind, and we take well-deserved pride in these achievements."

This organized medical federation of ours, then, *must* oppose arbitrary and unwarranted government programs or proposals which—taken together—threaten the very structure of medical education and practice in this country. The AMA will do what it has to do to preserve that structure, in the conference room or the courtroom, no matter what the cost in time or money.

At the same time, however, it seems to have escaped the attention of those in government—and even some physicians—that this federation is also *for* a *multitude* of programs to elevate the health and life-style of each American—and this includes reasonable government programs.

Within the past few years, the AMA has initiated or supported programs, including government programs, to upgrade health services—

... for the emotionally ill

... for the jail inmate

... for the alcoholic

... for the American Indian

... for the migrant worker

... for the rural dweller

... and for the inner-city resident.

Within the past few months, the AMA's crusade against excessive violence on television has earned nationwide attention.

We have introduced in Congress a national health insurance bill which would maximize health-care protection for all Americans, utilizing the present, pluralistic health care system, while minimizing federal supervision and new federal spending.

We have established a blue-ribbon National Commission on the Cost of Medical Care, representing many walks of life, to review and evaluate information that can place cost

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\*Presented at the Third Annual Governor's Conference, 211th Annual Meeting, the Medical Society of New Jersey, Atlantic City, May 14, 1977.



problems in correct perspective—so that suggested remedies can be equally correct.

The AMA played a major part in preventing a drastic cutback in Social Security funds for maternal, child-health, and crippled children's services.

### Summary

The very fact that the quality of American medicine *has* attained international pre-eminence indicates that our profession and this federation have done and are doing a lot of things right. Equally important, the general public is well aware of it. In one recent poll, the public placed more trust in the AMA than in any other organization of its kind. And in a number of previous polls, the public has accorded our profession more trust than any other. Therefore, in the difficult times ahead, let this faith be our fortress and let us *not* forsake it.

## Health Care Financing — Public or Private?

William C. White, Jr., C.L.U.

Vice President, Governmental Health  
Programs Office, The Prudential Insurance  
Company of America

I was asked to speak today on the subject of National Health Insurance and my predictions as to the enactment of legislation relating to this subject. I do not like the term, "national health insurance," but I have been unable to arrive at a different title for this broad subject. National health insurance means so many different things to different people ranging from a complete federal takeover of the health care system and its financing, as envisioned in the Kennedy-Corman Bill, to proposed legisla-

tion that would preserve the private health care sector as exemplified by bills supported by the American Medical Association, the Health Insurance Association of America, and the Chamber of Commerce of the United States.

I do not intend to analyze any of these bills since this has been done so many times before in meetings and in publications and, also, because I do not believe that any of these bills will ever be enacted in their present form.

Before looking down the road to the enactment of so-called national health insurance legislation, I think it is more important to consider what is happening under existing statutes and proposed legislation for the provision and financing of health care short of comprehensive health care financing legislation.

### Health Systems Agencies

Under existing laws, Health Systems Agencies (HSA) are functioning, or are beginning to function, throughout the country. These organizations have an important role in determining the future of health care institutions in this country. The concept of the HSA's, tied in with Certificate of Need legislation in each of the states, is to control the quality and costs of health care services rendered in the institutional setting. As you know, Boards of Directors of HSA's, by law, must be composed of a majority of consumers. As these organizations gain experience and fully exercise the powers granted to them, they will have a significant impact on the size and location of health care institutions and the extent to which these institutions may make capital expenditures for sophisticated technical devices and services.

There are many proposals under consideration by Congress to strengthen even further the role of the HSA's. An example is the desire to broaden the definition of a health care facility to include physicians' offices, clinics, and any other facility rendering health care services, so that the Certificate of Need legislation would apply to all health care facilities within a state. One reason for this approach is the purchase and operating cost of computerized tomography

\*Presented at the Third Annual Governor's Conference, 211th Annual Meeting, the Medical Society of New Jersey, Atlantic City, May 14, 1977.

(CT) equipment. The HSA's are attempting to limit the number of CT scanners in hospitals within a given geographic area, but this control measure may be subverted if a group of physicians in that area purchase a scanner for use in a clinic or office. The same principle would apply to other major capital expenditures for sophisticated technical equipment which we'll be seeing more of because of rapid advances in Biomedical-engineering technology. I expect that no action will be taken this year to amend the HSA law because of time limitations. The current law expires June 30, 1977 and I anticipate that Congress will merely extend the law for another year in order to have time for consideration of significant amendments to be enacted with an effective date of July 1, 1978.

### **PSRO's**

PSRO's are in place and operating in many areas of the country. However, they are operating under conditional approval only. Some areas are without PSRO's. Under the law, the Secretary of the U.S. Department of HEW, on January 1, 1978, must designate alternate organizations to serve the functions of the PSRO in any area without a working PSRO. In preparation for the required action January 1, 1978, the Secretary of HEW is holding hearings and has requested written comments on criteria to be established for determining an eligible organization to perform the PSRO function. If the physicians around the country do not support and cooperate actively with physician-controlled PSRO's, some other type of organization will perform the utilization review function because the government does not intend to leave a void in this very critical area of controlling health care quality and cost.

### **Health Maintenance Organizations (HMO)**

A few years ago, Health Maintenance Organizations were touted as the panacea for the solution of all the problems of health care delivery, quality, and cost. Over the past five years, it has become evident that HMO's will not spring up automatically at every crossroad in the country. On the other hand, it is good that a more cautious approach is being taken in

the organization and operation of HMO's; certainly some of them are doing a fine job. I think that there will be a continued growth of these organizations over the coming years, but I do not anticipate that they will replace completely the practice of medicine through solo practitioners and groups of practitioners as we now have them.

### **Medicare-Medicaid**

We cannot deny that there's a certain amount of fraud and an even greater amount of abuse in the provision of health care services under the Medicare and Medicaid program. The hue and cry raised in the press on this subject forces Congress to take action to control fraud and abuse and to punish severely those who are found guilty of fraudulent or abusive actions. A limited attempt in this regard is seen in the current legislation before the Congress; namely, H. R. 3, Medicare-Medicaid Anti-Fraud and Abuse Amendments. This legislation alone will not solve the problem but, coupled with the operation of the new Inspector General's office in the Department of Health, Education and Welfare and stepped-up activities in the Attorney General's office, the result will be more publicity on punitive actions being taken by the government. This is an effort to eliminate fraud and control abuses under the very expensive Medicare and Medicaid programs.

Senator Herman Talmadge (this month) has introduced a revised bill on Medicare-Medicaid Administrative and Reimbursement Reforms. This bill is somewhat different from the one introduced by Senator Talmadge in the prior session of Congress, but basically it attempts to achieve the same goals as set forth in the earlier bill. This bill would attempt to control hospital costs under the Medicare and Medicaid programs, but this time with a further provision that hospitals will be required to agree not to pass along to any other payors, such as Blue Cross or private health insurers, any costs that are determined excessive under Medicare and Medicaid. Since the reimbursable costs under Medicare and Medicaid will be limited to 120 percent of the average costs of all hospitals in a similar class of institution, obviously, some hospitals are going to be left

without reimbursement by anyone for a significant portion of their cost. This, of course, will impair seriously the ability of these hospitals to continue to provide all of their usual services; in fact, it could result in the closing of some institutions. There is another provision in the bill to promote the closing and conversion of under-utilized facilities. These two provisions may have a significant effect on the distribution of hospital beds in any given area.

The Talmadge Bill proposes also to go the Blue Shield route under Medicare by establishing "participating" and "nonparticipating" physicians for the purpose of paying benefits. In order to be classed as a participating physician, the physician must agree to accept the reasonable charge determination made by the carrier as his full charge for service rendered. There is a nominal incentive to encourage physicians to participate. The bill provides that claims may be submitted on multiple listings or other simplified forms to save office expenses and, further, that one additional dollar will be paid by the carrier for each claim submitted. On the other hand, the bill also proposes further to limit the increase in prevailing charges in an area. An addition to the current limits, accomplished through the definition of a prevailing charge, would be the 75th percentile of all customary charges limited by the application of an economic index factor. *One hand giveth and the other taketh away.*

There are other provisions in this bill which will affect physicians, including the reimbursement of hospital-associated physicians and various other billing-payment procedures.

President Carter has recommended to Congress that increases in payments for inpatient care and acute care, especially in hospitals, be limited to nine percent per annum. While there are some provisions for exceptions to this limit which will recognize exceptional changes in patient load, major increases in capacity or types of services provided, the application of this percentage limit on a national basis could cause severe problems for individual hospitals throughout the country since not all hospitals are alike. The HEW staff has controls on

physician charges under consideration for recommendation to the President but, at this time, there is a lack of unanimity among the HEW advisers as to the best method of controlling physician charges. A recommendation in this regard may be made to the President later.

### Effects on Physicians

All of these things have or will have a direct or indirect effect on each physician. Each of the above programs or actions or proposed legislation are piecemeal efforts to meet the very serious problem of the rapid escalation of health care costs. In the end, all of these programs or actions may decide the future course of so-called national health insurance legislation. On the one hand, the administration and some members of Congress feel that a comprehensive approach to the financing and control of health care through sweeping federal legislation is the only answer to the control of health care costs. On the other hand, if the escalation of health care costs continues, the cost of a federally funded and administered national health insurance program would be so enormous as to make it impossible to finance through the federal budget without tremendous tax increases. There will be continued efforts, therefore, to control the costs of the Medicare and Medicaid programs and to extend those controls to the private sector of health care before enacting national health insurance legislation. Again, however, if the escalation in health care costs can be reduced or contained, there's a better hope for the enactment of legislation providing for the continuation of the private financing of health care for the majority of the population.

### Predictions

I expect that during this session of Congress, there will be no comprehensive national health insurance legislation passed. I do expect that something similar to the anti-fraud and abuse amendments and the Talmadge Bill may be enacted by next year. Also next year, there may be legislation enacted further to strengthen the role of the HSA's. Possibly during 1978, the administration may introduce legislation to



provide for incremental steps toward national health insurance, but I doubt the enactment of such legislation before 1979 or 1980. Examples of this approach might be the provision of maternal and child care or some type of catastrophic medical expense program.

We should not be lulled in a state of apathy with respect to the enactment of comprehensive national health insurance legislation by the incremental approach just mentioned. Catastrophic medical expense insurance has broad popular appeal and might appear to the Congress as the easy way out of facing up to health care financing problems. If the catastrophic insurance program is federally financed through payroll taxes, the way is cleared for the extension of this program into a broad health insurance program financed through the Federal Government. Most of the catastrophic proposals envision a rather large deductible, but if such a program were enacted, it would be politically inevitable that Congress will act to reduce that deductible and eventually reach the point that all health care expenses would be paid for through the Federal Government.

The same possibilities for expansion exist in the incremental approach of financing health care costs for maternal and child care.

If the President continues to hold his policy position that the federal budget should be balanced by fiscal year 1981, it seems highly unlikely that he will propose an expensive comprehensive national health insurance program. On the other hand, he is committed to the introduction of some form of health insurance legislation. This leads me to believe that he will propose some incremental approach to satisfy his commitment on national health insurance, but that it will be a relatively inexpensive program.

### Warning

We all must be alert, therefore, to continue our educational efforts with the public and especially with the Congress as to the long-run dangers of the piecemeal approach. I hope that all New Jersey physicians will consider this matter seriously because I am well aware that many

physician organizations, including groups within the American Medical Association, endorse the concept of catastrophic medical expense insurance. There are one hundred million people covered by major medical insurance through private insurance companies. I hope that we can find ways to encourage the extension of the private coverage to more people through legislative assistance. But, to endorse catastrophic medical expense insurance financed through the Federal Government is to endorse the first step for comprehensive national health insurance financed and administered by the government.

As has been the case for many years, we rarely face the prospect of socialism in one fell swoop, but rather the prospect of socialism through gradualism.

## State Problems in Government and Medicine

Gerald J. Reilly  
Acting Deputy Commissioner, New Jersey  
Department of Human Services

The Medical Society of New Jersey has a long and tested history of outstanding contributions to the advance of medicine and to the general well-being of our State and its citizens. I consider it a genuine privilege to be asked to address such a distinguished group. My assigned task is to discuss with you the problems of Government and Medicine from a state perspective.

The first problem is that of holding down costs versus appropriate compensation for highly skilled professional services. The second is the challenge of building workable regulatory frameworks versus the preservation of the free and creative practice of the healing arts. And the third is the task of building a constructive

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\*Presented at the Third Annual Governor's Conference, 211th Annual Meeting, the Medical Society of New Jersey, Atlantic City, May 14, 1977.

partnership between medicine and government versus open conflict or, at best, an uneasy truce.

Each of these issues is not only complex and intertwined, but each has a set of national and local implications. I share some thoughts with you from the perspective I gained during my two-year tenure as Director of the New Jersey Medical Assistance program.

### **Cost Containment**

Cost containment in the health sector has become one of the leading issues of our time. You are well aware that the issue is occupying the attention of public officials from the White House on down, and no wonder! We are told by the economists that health costs have grown to 8.6 percent of our Gross National Product: \$129 billion in 1976, double the amount in 1970. We are informed that the cost of health care is growing at a rate twice that of other goods and services in the economy. Predictably, a strong reaction has developed to this trend, and also predictably, the crunch is being felt first by the governmentally financed health programs.

The following is a specific example from our own State. Two years ago, New Jersey was caught in a fiscal squeeze. In an effort to help balance a potentially deficit budget, Medicaid was forced to reduce already inadequate provider fees by 10 percent. Such a strategy for cost containment is, in the long run, counter-productive, as it tends further to reduce the access of Medicaid recipients to individual private practitioners. This reduced access can lead to treatment in more costly clinics or postponement of treatment, resulting in more serious illness and very expensive hospitalization. Why then did we take such a step? We did so for two very simple reasons. First, we were constrained by federal law that effectively blocked us from having hospitals assume a fair share of the cut-back. We tested this law, but lost the battle in federal court. And second, the fee reduction did have the short-term impact of saving money and helping us to balance the budget. Its very harmful effects are a longer-term proposition, and, unfortunately, govern-

mental entities have great difficulty in planning beyond a very limited time horizon. The harsh realities of balanced budgets and limited revenues force us to focus attention on short-term solutions. Eventually, in February of this year, we were able to restore the fees to their previous level, but not before a 38 percent increase in the use of outpatient departments had occurred. These outpatient facilities fill a vital need in many older urban areas, but they are an expensive way to furnish primary care.

In my view, a rational cost-containment strategy must include the payment of reasonable fees to physicians and other health care practitioners. It should be stressed that physician fees account for only 11 percent of Medicaid expenditures in New Jersey, but you serve as the principal gatekeepers for access to most of the other services in our 500 million dollar Medicaid program. A system that does not permit a government program, especially Medicaid, to compete on a reasonably comparable basis with private sector fees cannot hope to employ fully the resources of the medical community in effectively dealing with our shared problem of seemingly uncontrollable health costs. I firmly believe that our current policy of paying about 50 percent of the usual and customary charge is unsound. I think that payment of a fairer fee would be cost effective in the long run by enlisting broader physician participation, by keeping people well, and by providing alternatives to costly clinic operations. Legislation introduced by Senator Talmadge in the Congress last session would have set Medicaid fees at 80 percent of the usual and customary level. This bill is scheduled for reintroduction this session, and I hope it continues to include this provision. I think, however, it also should include some special financial provisions to help states absorb this change. For example, here at home this proposed legislation would cost New Jersey alone 18 million dollars. I must add, as a balancing note, that such a commitment to reasonable parity with the private sector cannot be open-ended. No parity can be feasible, in my view, unless methods also can be found to limit growth in private health fees to non-inflationary levels.

## Regulation

Turning to the issue of regulatory frameworks, I share your sense of frustration that many of you have expressed to me in private conversations. We all are caught in the same trap. The cycle often begins with the establishment of a worthwhile public program, followed by expenditures of large amounts of public funds, followed by advantage-taking by a few, and finally the mailed fist of regulation descending upon the many to correct the sins of a few. There are, it seems to me, three broad approaches to dealing with the issue of regulations.

First, we public officials could administer the program with a minimal insistence on accountability and extreme restraint with regard to involvement or interference with the traditional mores and methods of the private health care sector. In so doing, we would have to be willing to accept the fact that some unscrupulous individuals would profit unduly at public expense and be willing to accept such a loss as tolerable in comparison with the costs in freedom and initiative that accountability sometimes entails.

Second, we could construct a system designed to ensure that no one ever receives a dime to which he is not absolutely entitled. Such an approach can conceive of no regulation too burdensome and no form too cumbersome and no demand too unreasonable but to expect absolute conformity on the part of participating providers.

Third, and, at least in my mind, the most sensible alternative, is to seek that illusive pivot point at which the public's right to be assured of proper stewardship of tax dollars, and the practitioner's right to the free pursuit of his or her professional responsibilities is sensibly balanced. Such a system needs to assure the high probability that the few scoundrels will be found out and removed, and yet involve minimum interference in the lives of the vast majority. In the New Jersey Medicaid program we have tried to operate according to this third approach. Sometimes we have failed, and sometimes we have succeeded.

You and I might not agree on the frequency of success, and I concede that finding the proper balance is very difficult and subject to frequent re-evaluation. I am concerned, however, that if we together are not able to find a workable solution, strong pressures will build particularly at the national level, to move us farther along the path to the heavy-handed approach of mindless regulation. The source of this pressure is a sense of frustration in dealing with the often-sensationalized antics of the dedicated chiseler, sensationalized to the point, sadly, that Medicaid fraud has become one word. We are driven to seek simplistic solutions that provide us comfort in the belief that if something must be done, almost anything will suffice.

## A Constructive Partnership Between Medicine and Government

I have found it is frequently true that, when these simplistic solutions are designed from afar, they most often create more problems than they solve. Washington appears to be much farther from New Jersey, in outlook and comprehension of problems, than the mere 120 physical miles of separation. Many in Washington seem to believe that all wisdom ends at the banks of the Potomac and that we in the provinces don't understand the larger picture. I make this statement not out of a jingoistic or quixotic attachment to states' rights, but from a much-considered belief that we must try to solve many of our national problems at the lowest practicable level. I firmly believe that the time has come for a reassertion of a responsible state role in many issues, including health care. I also firmly believe that we *must* include, as a key participant in the exercise of this responsible state role, the voice of the state medical society. We must build a fair and sound relationship between government and medicine. Unfortunately, there has been a tendency for government, at both the state and federal levels, to discount the value of formal comments from the medical community. Perhaps this is because of the seemingly negative tone in which some spokesmen for organized medicine have, in the past, offered their criticism. Public officials have been conditioned to tune out messages sent



from the nation's doctors. Fault can be found with both parties for this condition. But I think the time is long past for digging in our heels and glaring at each other across the abyss of misunderstanding and mistrust. Physicians *must* be included in the deliberations about governmental health policy. Not by virtue of their numbers, and perceived vested interest, but through the weight and cogency of their constructive contribution to the dialogue. Without doubt, there are, and will continue to be, issues upon which disagreement will occur. I think, however, that we will find more common ground than we might recognize before beginning the effort.

I have had two recent experiences that strongly reinforce this view. The first is here in New Jersey, the second in Washington. In our own state, during the past eleven months, I and members of my staff have been meeting on a monthly basis with the Medicaid Committee of your society, a Committee most ably chaired by Dr. Harvey Shwed. In my view, these meetings have been beneficial, and I have been able to learn a great deal about your perceptions of our program. I have been most impressed by the ability of the committee members to deal objectively with the issues discussed. The second involves my participation in a series of meetings recently held in Washington with the administrator of the new Health Care Financing Administration, several state Medicaid directors, and national physician leaders of the PSRO (Professional Standards Review Organization) program. My colleague Medicaid directors and I were amazed to find that we and the physicians had very few differences. Most of the difficulty had to do with attitudes of some HEW staff.

The three Medicaid directors and the PSRO doctors seemed to share the same goals.

We were interested in providing decent care at an affordable price through a common-sense approach to the problems. The result was a series of recommended legislative changes in the PSRO law that we all agreed would help us to achieve these health-care goals. The opportunities for such cooperation are limitless, and the positive and open approach of your state society is evidenced by both the work of Dr. Shwed's committee and by your permitting me to address this group.

In summary, I believe that together we can make progress with regard to the three issues I have discussed. We can improve the quality and scope of essential services to our poorest citizens. First, we need a fair and equitable fee system that does not require a physician to subsidize the public program. Second, we need a regulatory framework that strives to limit interference in private practice to that which is minimally necessary effectively to manage the program. And third, we need to work very hard at keeping open the channels of communication among ourselves, particularly at this time of evolving national policy between us in New Jersey and the elected and appointed officials in Washington.

In conclusion, I want to thank you for this opportunity to share some of my thoughts with you, and I invite you to reciprocate throughout the months ahead as we continue to work together. We may not always agree, but we owe it to each other, at least, always to listen.

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## New Double-Blind Study ANDROID-25 vs. Placebo\*

\* **WRITE FOR REPRINT:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D., *Hormones for Improved Sexuality in the Male and Female Climacteric. Drug Therapy*, Sept. 1976.

Is there a true aphrodisiac? How effective are androgens in the management of the male climacteric and male impotence? Article discusses the psychophysiological and hormonal changes in the elderly male and female and therapeutic considerations. The effectiveness of methyltestosterone in the management of male impotence was confirmed by a cross-over, double-blind study using a placebo and Android-25

(methyltestosterone 25 mg.), on 20 males, 50 years of age or older who complained of secondary impotence. Patients received a series of placebo then Android-25, or Android-25 then placebo as follows: 1 tablet/30 days; 2 tablets/30 days; 3 tablets/30 days. Sexual response was evaluated: 0 = no change; + = 25% improvement; ++ = 50% improvement; +++ = 75% improvement. Placebo effectiveness was + or ++ in 12.7% of trials. Android-25 elicited a +, ++ or +++ response in 47.2% of trials. There was often a dose related response not observed with the placebo. This effect was not observed in younger patients (age 28-45 years).

**DESCRIPTION:** Methyltestosterone is 17 $\beta$ -Hydroxy-17-Methylandroster-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-pubertal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

**REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpubertal cryptorchism, 30 mg. **REFERENCE:** Robert B. Greenblatt, M.D., and D. H. Perez, M.D.: "The Menopausal Syndrome," *Problems of Libido in the Elderly*, pp. 95-101. Medcom Press, N.Y., 1974. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.



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# TRANSACTIONS

## 1977 House of Delegates

### 211th ANNUAL MEETING

The Medical Society of New Jersey

May 14-17, 1977



President Madara receiving Fellow's Key from Immediate-Past President Rogers



President Madara—Farewell Address



Incoming President Begen receiving President's Plaque from President Madara.



Incoming President Begen—Inaugural Address

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# ANNUAL REPORTS

## President

**John S. Madara, M.D., Salem**

(Reference Committee "A")

Our Constitution states that the President "... shall appoint committee members... and he shall be an ex-officio member of all committees except the Nominating Committee. He shall be the official spokesman of this Society. . . ."

To assume that the President is the hub of the activity of The Medical Society of New Jersey is in error. It is more realistic to picture the President's position as that of the rim of the wheel that is in contact with all the spokes (representing the Society's councils and committees) and that, in turn, comes in contact with the vast outside world—the environmental force that influences our Society and that we, in turn, leave our tread marks on.

This year we have traveled over many hills and valleys, but let me first mention the spokes of the wheel. Fortunately for our Society, we have had at the hub two men whose abilities are recognized: one, Doctor James S. Todd, the Chairman of the Board of Trustees, for his ability to handle a meeting, to shape opinion, and to think logically; the other, Mr. Vincent A. Maressa, our Executive Director, for his uncanny ability to predict outcomes, his legislative thinking, and his efforts to reason with the unreasonable. These two men deserve our commendation for being a strong axle around which our committees revolve.

As President and ex-officio member of all committees except the Nominating Committee, I wish I had had more time to meet with our councils and committees. I was able to attend, at one time or other throughout the past year, meetings of the Council on Legislation, the Council on Public Health, the Annual Meeting Committee, Medicaid Committee, JEMPAC, the Special Committee on Occupational Health, Workmen's Compensation and Rehabilitation,

the Ad Hoc Committee on Professional Liability, the Standing Committee on Medical Defense and Insurance, and the AMA Delegates and Alternates.

### EXECUTIVE COMMITTEE

The Executive Committee (composed of myself as Chairman, President-Elect Frank R. Begen, M.D., First Vice-President Charles S. Krueger, M.D., Second Vice-President Alfred A. Alessi, M.D., Chairman of the Board James S. Todd, M.D., and Executive Director Mr. Vincent A. Maressa) met alone at least four times during the year, and at other times with the Executive Committee of the New Jersey Hospital Association, New Jersey Association of Ophthalmology and Otolaryngology, the Medicaid Committee, the Special Committee on Long Range Planning and Development, and representatives of Middlesex County Medical Society.

### BLUE SHIELD

As an official member of the Board of Trustees of the Medical-Surgical Plan of New Jersey, I attended at least eight of the monthly Trustees' meetings held at the Downtown Club in Newark, as well as the meeting of the Quadripartite Permanent Committee, held on September 29, 1976, at the offices of Blue Cross and Blue Shield in Newark. (This Committee consists of representatives of the Hospital-Service Plan, Medical-Surgical Plan of New Jersey, New Jersey Hospital Association, and The Medical Society of New Jersey.)

### STATE AND NATIONAL MEETINGS

One of the pleasures of representing an old and honored Medical Society is being invited to meetings with committees of other professional groups. I enjoyed attending the:

Annual AMA Convention in Dallas, in June, 1976; Clinical Conference in Philadelphia, in December, 1976; AMA Leadership Conference in Chicago, January, 1977; AMA Seminar on the Art of Negotiations at Valley Forge, in January, 1977; AHA Annual Conference in Dallas, in December, 1976; AHA Annual Meeting in Washington, in January-February, 1977; AHA Committee on Physicians, in February and April, 1977; as well as meetings of:

Regional Advisory II of the AHA in Gettysburg, in August, 1976, Montauk Point, Long Island, in October, 1976, New York City, in January, 1977; Annual Meeting of the New Jersey State Nurses' Association in Cherry Hill, in October, 1976; Meeting of the House of Delegates of the New Jersey Association of Family Physicians in East Brunswick, on March 13, 1977, and its Annual Convention in Puerto Rico, in March, 1977; Annual Meeting of the Philippine-American Medical Society of New Jersey in Cherry Hill, in August 1976; The Pennsylvania Medical Society at the (since closed) Bellevue-Stratford, in September, 1976; the Medical Society of Delaware in Wilmington, in October, 1976; and The Medical and Chirurgical Faculty of Maryland, in April, 1977.

#### OFFICIAL SPEECHES AND PUBLIC INTERVIEWS

One of the duties of the President is "to be the official spokesman of this Society." In carrying out this function, I:

Gave a talk at McGuire Air Force Base on June 23, 1976, on "Influenza 1976 As Viewed By the Medical Profession";

Appeared on television three times: Once, in October, 1976, with the much-publicized Doctor Peter DeMarco; once, in December, 1976, to discuss "Medicaid" on the Joel A. Spivak program; and a television news conference in January, 1977 (when Commissioner of Health, Joanne Finley, introduced me as "Doctor Clayton Madara") to discuss our approval of the "Guidelines for Health Care Facilities to Implement Procedures Concerning the Comatose and Non-Cognitive Patient."

There were also radio interviews:

Delaware Valley Hot Line (WSNJ) in July, 1976; Medical Forum Interview on WTTM (Trenton) in September, 1976, with Doctor Rudolph C. Gering and Doctor Arthur A. Sacks-Wilner; and WJIC in Salem in December, 1976.

#### OTHER PROFESSIONAL GROUPS

I also was privileged to represent our Society at the:

State-wide Leadership Conference on Influenza Vaccination in June, 1976; Meeting of the Inter-professional Council in September, 1976; Combined meeting of officers of the Medical Societies of Delaware, Maryland, Pennsylvania and New Jersey, in Lemoyne, Pennsylvania in November, 1976; Academy of Medicine in November, 1976 and May, 1977; State Medical Association Presidents in Philadelphia in December, 1976; Carrier Clinic Foundation Luncheon to honor Chief Justice Richard J. Hughes at Belle Mead in December, 1976; and Advisory Committee on Alternative Health Care Delivery Systems in Trenton in February, 1977.

#### COUNTY MEETINGS

Among the welcomed invitations extended to your President are those for dinners, annual banquets, and dances, of component county societies. The counties visited were: Middlesex, Morris, Camden, Passaic, Bergen, Gloucester, Mercer, Burlington, Union, Hudson, and (of course) Salem.

#### SPECIAL COMMITTEES

I would like to give particular recognition to five Special Committees I was privileged to appoint this year:

1. Special Committee to Study Admission of Osteopaths to Our Society. It was chaired by Doctor Sherman Garrison, and its members were: Doctor Francis X. Keeley, Doctor Charles S. Krueger, Doctor Howard H. Lehr, and Doctor Stephen Levine.



On the recommendation of this Committee, the Board of Trustees voted, on October 17, 1976, to recommend that our Society's Constitution and Bylaws be amended to admit Doctors of Osteopathy into The Medical Society of New Jersey.

2. Special Committee on Conservation of Hearing and Speech, which was reorganized under the chairmanship of Doctor Aris M. Sophocles in September, 1976, and is planning a scientific exhibit at this year's annual convention.

3. The Ad Hoc Committee to Study a Medical Directorship for MSNJ. This committee consisted of: Doctor James A. Rogers, as Chairman, and Doctor David R. Brewer, Jr., Doctor David Eckstein, Doctor Charles S. Krueger, and Doctor Henry J. Mineur.

It concluded that there is no overriding reason for entertaining a physician as a staff person to the Society at this time.

4. The Ad Hoc Committee on Atomic Energy Plants, under the chairmanship of Doctor Howard D. Slobodien, has held a series of meetings with atomic energy experts and will report its findings to the 1977 House of Delegates.

5. The Ad Hoc Committee on the "Impaired Physician" has been chaired by Doctor Arthur McLellan and will also report to the House of Delegates at the Annual Convention.

#### SUCCESSSES

Undoubtedly, the historical accomplishment of this year's efforts has been the formation of our own insurance company, which owes its existence to the unceasing efforts of the Chairman of the Ad Hoc Committee on Professional Liability, Doctor James S. Todd; the Medical Director of the Department of Professional Liability, Doctor James George; the Chairman of the Committee on Medical Defense and Insurance, Doctor Paul Kreutz; the Executive Director of The Medical Society of New Jersey, Mr. Vincent A. Maressa; and the Speaker of the House, Doctor Henry Mineur, who guided the special session of our House of De-

gates in its discussion and final approval. Credit should also be given to Mr. Robert Chapman and Doctor Michael Beams, of the New Jersey Association of Osteopathic Physicians and Surgeons, who worked on the Steering Committee.

Another landmark was the approval (along with the New Jersey Hospital Association and the New Jersey Association of Osteopathic Physicians and Surgeons) of the "Guidelines for Health Care Facilities to Implement Procedures Concerning the Comatose and Non-Cognitive Patient."

The Medical Society of New Jersey cooperated with New Jersey Osteopathic Physicians and Surgeons in supporting the A/New Jersey/76 Influenza Immunization Program, which was successful until a series of adverse happenings brought it to a close.

#### FAILURES

Among the disappointments of this past year has been the lack of a workable liaison with our State Government, as evidenced by:

(a) Support of litigation for approval of the purchase of computerized axial tomography scanners by physicians, and threat of further litigation if the Commissioner of Health determines that physicians in private practice are to be within the scope of Certificate of Need legislation.

(b) Unsuccessful support of the basic philosophy of medical management of New Jersey psychiatric hospitals by board-certified psychiatrists.

(c) Failure to convince the Commissioner of Health of certain irregularities in the formation, advertising, financing, and staffing of the Rutgers HMO.

Two other areas of disappointment still require our activities in the future:

(a) A concerted effort to get our professional liability legislative package passed by the Legislature, and signed by the Governor.

(b) A strong push to re-enlist those of our members who have resigned from the American Medical Association, since this year we lost one delegate and one alternate.

#### SPECIFIC RECOMMENDATIONS

1. That, as approved by the Board of Trustees on January 16, 1977, the Standing Committee on the Revision of Constitution and Bylaws adopt the following mechanism for adjusting the number of seats authorized by the AMA:

"If, in the future, The Medical Society of New Jersey becomes eligible for another AMA seat in the House of Delegates, this delegate should be the incumbent President, and the Alternate should be the incumbent President-Elect. In this way, the top officials of our Society would be delegates at a time when they were most knowledgeable. If it should become necessary to lose a Delegate because a seat is not authorized, the President and President-Elect could then be dropped from the list of delegates but still be authorized to attend the convention as non-delegates as at present. In this way, there is enough flexibility to adjust the delegates to conform to the seats authorized each year without losing elected delegates."

2. That, as recommended by the Special Com-

mittee on Long Range Planning and Development and approved by the Board of Trustees on January 16, 1977, the Standing Committee on Revision of Constitution and Bylaws be directed to develop the appropriate Bylaw language:

(a) To merge the duties of the Secretary of the Board of Trustees with those of the Secretary of the Society;

(b) To allow appointment of the Chairman of the Board by the President, with the advice and consent of the Board of Trustees; and

(c) To include the immediate past President as a member of the Executive Committee.

3. That, as recommended by your President at the Board of Trustees meeting on February 23, 1977, the Bylaws of The Medical Society of New Jersey be changed to allow special membership for medical students from any approved medical school in the United States.

4. That, as recommended by the Board of Trustees on October 17, 1976, our Bylaws be amended to admit Doctors of Osteopathy into our Society.

Filed with commendation (page Tr 128)

#### ACTION TO LIMIT DEBATE

At its first session on Saturday, May 14, 1977, the House of Delegates agreed, upon motion, that no one may speak more than once on any given subject except in rebuttal or by express permission of the House, and that floor time in each instance shall be limited to four (4) minutes unless exception is made by the House.

# Secretary

Arthur Bernstein, M.D., Maplewood

(Reference Committee "A")

The office of the Secretary has continued its usual routines, primarily involving maintenance of membership records, correspondence, telephone inquiries, and completion of numerous questionnaires originating from various sources.

During the administrative year, the Secretary attended the meetings of the Board of Trustees and the several committees of which he is chairman, member, or advisor.

## MEMBERSHIP (as of December 31, 1976)

Active: Paid	8,229	
Exempt	854	9,083***
*Associate: Paid	87	
**Affiliate: Paid	56	
Exempt	1	
State Emeritus	425	
Total of Above	9,652	
State Honorary	8	
New and Reinstated Members:		
Active	735	
*Associate	87	
**Affiliate	3	
Transfers within the state	44	
Transfers out-of-state and resignations	116	
Members deceased	131	
Members dropped:		
Active (non-payment of dues)	91	
(N.J. licensure revoked)	1	
(N.J. licensure suspended)	1	
(N.J. licensure voluntarily surrendered)	2	
(N.J. licensure resigned)	2	
*Associate (non-payment of dues)	1	
**Affiliate (non-payment of dues)	0	98

\*Associate membership (non-licensed in N.J.) designates interns and residents.

\*\*Affiliate membership-physicians who no longer practice in New Jersey.

\*\*\*Adjusted for transfers out-of-state, resignations, and deaths.

## AMA MEMBERSHIP

A total of 6,445 members of The Medical Society of New Jersey maintain active membership in the AMA. The Society's representation in the AMA House of Delegates stands at seven delegates—one for each thousand members, or fraction thereof.

## MEMBERSHIP DIRECTORY

In January 1977, the completion of the 1976-77 edition of the *Membership Directory* was announced. Distribution to the entire membership was made the same month.

Basically the new *Directory* embodied the same features as that of the 1974-75 edition, and includes: the supplement section which contains the Constitution and Bylaws of MSNJ, the AMA Principles of Medical Ethics, the Basic Concepts Underlying the Provision of Professional Medical Care, Legal Obligations Affecting Medical Practitioners, Guides for Physician-Hospital Relationships in New Jersey, and a list of Poison Control Centers in New Jersey.

Again, an expression of gratitude is in order for the cooperation received from the membership in assisting us to produce this *Directory*.

Filed (page Tr 129)



# Treasurer

Rudolph C. Gering, M.D., Trenton

(Reference Committee "B")

This 1977 interim financial report of your Treasurer has been prepared from the books and records of The Medical Society of New Jersey.

The Balance Sheet is presented as of March 31, 1977 and May 31, 1976. Figures at March 31, 1977 have not been audited, for the reason that the fiscal year of the Society does not end until May 31, 1977. The figures at May 31, 1976 have been abstracted from the report of audit dated August 21, 1976.

The Statement of Revenue, Expenditures, and General Surplus Unappropriated presents the transactions of the Society for the ten months ended March 31, 1977 and the year ended May 31, 1976.

Revenues have been examined on a test basis and disbursements have been test checked to approved supporting vouchers by the Society's independent accountants. The cash balances

at March 31, 1977 were reconciled with the bank statements but were not confirmed directly with the depositories. Revenues from counties for dues assessments were checked in detail to reports on file, but were not confirmed with county treasurers at this time. Investments were not physically examined or confirmed at March 31, 1977.

These financial statements have been prepared in a form similar to the annual audit report, in order to show in greater detail the assets, liabilities, fund balances, operating revenues, and expenditures of the Society, in conformity with Resolution #28 approved by the 1968 House of Delegates under the heading "Annual Financial Report."

Filed (page Tr 130)

It was the recommendation of Reference Committee "B" that the annual reports of the Treasurer and the Committee on Finance and Budget be mailed to the delegates with the other annual reports prior to the Annual Meeting, when technically feasible.

## BALANCE SHEET—GENERAL FUND

Assets	March 31, 1977 (Unaudited)	May 31, 1976 (Audited)
Cash	\$1,552,346.82	\$ 634,068.40
General Fund Investment Portfolio— at cost (Page 17)	189,815.63	189,579.88
General Fund Saving Certificates	— 0 —	260,000.00
Note Receivable—N.J. State Medical Underwriters, Inc.	107,093.03	— 0 —
Notes Receivable—Physicians	15,600.00	— 0 —
Accounts Receivable	3,005.65	8,119.72
Inventories—at cost		
Maternity Service Record Books	3,718.62	4,150.02
"The Healing Art" Books	3,714.16	3,734.16
Land, Building and Equipment—at cost	355,859.13	355,859.13
Deferred Expense—Construction Loan	46,500.00	54,000.00
Deferred Expense—Telephone System	15,533.00	18,703.00
Accrued Interest	4,298.49	8,576.34
Due from N.J. Foundation for Health Care Evaluation	718.59	— 0 —
Due from N.J. State Medical Underwriters, Inc.	3,092.22	— 0 —
Medical Student Loan Fund—Fire Extinguishers Inventory	383.25	— 0 —
Total Assets	<u>\$2,301,678.59</u>	<u>\$1,536,790.65</u>

**BALANCE SHEET— GENERAL FUND  
LIABILITIES AND FUND BALANCES**

	March 31, 1977 (Unaudited)	May 31, 1976 (Audited)
<b>Liabilities:</b>		
Unexpended Budget Appropriations (Page 12)	\$ 77,320.79	\$ — 0—
Notes Payable— Bank	15,533.00	18,703.00
Accounts Payable	900.00	77,861.25
AMA Collections Fees Payable	— 0—	5,917.50
Due to Physicians' Relief Fund	— 0—	40,555.50
Due to Medical Student Loan Fund	57,038.00	54,000.00
Deferred Income— Assessments Collected Applicable to Succeeding Year (Page 15)	405,556.69	456,411.03
Payroll Taxes Payable	3,592.02	2,326.25
AMA Voluntary Contributions	— 0—	30.00
N.J. Sales Tax Payable	343.60	— 0—
<b>Funds for Specific Purposes:</b>		
House Restoration & Replacement	3,840.79	11,339.24
Land, Building and Equipment	355,859.13	355,859.13
Maternity Service Record Books	3,718.62	4,150.02
Royalties on "The Healing Art"	419.50	925.50
"The Healing Art" Books	2,808.66	2,808.66
Membership Directory	24,102.34	3,902.34
Annual Meeting	13,885.73	— 0—
Mandatory Assessment Professional Liability	1,047,918.70	220,676.51
AMA Dues	28,000.00	25,250.00
N.J. Foundation for Health Care Evaluation— Assessments	31,680.00	— 0—
Litigation Fund Reserve	4,787.55	— 0—
General Fund Balance (Unappropriated)	224,373.47	247,074.72
<b>Total Liabilities and Fund Balances</b>	<u>\$2,301,678.59</u>	<u>\$1,536,790.65</u>

**STATEMENT OF REVENUE, EXPENDITURES  
AND GENERAL FUND BALANCE (UNAPPROPRIATED)**

	Ten Months Ended March 31, 1977 (Unaudited)	Year Ended May 31, 1976 (Audited)
<b>Revenue:</b>		
Assessments Earned (Page 15)	\$802,343.09	\$736,919.81
Income on Savings Accounts and Certificates of Deposit (Page 17)	39,058.95	20,205.98
Income on Investments (Page 17)	11,347.23	16,754.50
Interest Income PLI Notes Receivable	1,958.18	— 0—
Maternity Service Record Book Sales	431.40	842.14
"The Healing Art" Book Sales	— 0—	20.00
Rental Income— Net	688.97	3,288.97
<b>Total Revenue</b>	<u>\$855,827.82</u>	<u>\$778,031.40</u>
<b>Expenditures— Budget Appropriation (12 Months)— (Page 12)</b>	<b>\$858,914.00</b>	<b>\$703,904.61</b>
Excess of Expenditures over Revenue or Excess of Revenue over Expenditures	(\$ 3,086.18)	
Before Medical Journal Deficit and other Expenditures		\$ 74,126.79

Medical Journal, Annual Meeting and Prior Year's Income and Expenses		
Medical Journal Deficit	(\$ 56,626.18)	(\$ 57,468.16)
Annual Meeting	—0—	( 26,687.70)
Prior Year's Net Income and Expenditures	( 3,594.39)	241.33
	<u>(\$ 60,220.57)</u>	<u>(\$ 83,914.53)</u>
Net Increase (Decrease) in Fund Balance (Unappropriated) from Operations	(\$ 63,306.75)	(\$ 9,787.74)
Reclassification of Physicians' Relief Fund — Balance	\$ 40,605.50	—0—
	<u>(\$ 22,701.25)</u>	<u>(\$ 9,787.74)</u>
General Fund Balance (Unappropriated)		
Balance, Beginning	\$247,074.72	\$256,862.46
Balance, Ending	\$224,373.47	\$247,074.72

STATEMENT OF EXPENDITURES— GENERAL FUND  
FOR THE TEN MONTHS ENDED MARCH 31, 1977  
(UNAUDITED)

Account	Adopted Budget	Total Expended	Balance Unexpended
Executive Salaries	\$128,895.00	\$107,965.69	\$20,929.31
General Staff Salaries	262,708.50	210,150.12	52,558.38
General Executive Office Expense	39,000.00	35,960.48	3,039.52
Executive Travel	4,700.00	8,178.08	(3,478.08)
House Maintenance	36,800.00	35,304.59	1,495.41
Treasurer	11,800.00	11,047.48	752.52
Finance and Budget Committee	75.00	—0—	75.00
Secretary	1,700.00	—0—	1,700.00
Salary Taxes	21,200.50	16,926.42	4,274.08
Insurance	25,750.00	20,975.56	4,774.44
House Reserve	12,800.00	22,601.54	(9,801.54)
MSNJ Pension Plan	5,200.00	4,273.82	926.18
MSNJ Building Loan	12,240.00	10,200.00	2,040.00
AM-CAP Computer Program	23,500.00	232.85	23,267.15
Legislation	10,000.00	8,338.58	1,661.42
Council on Public Health	3,600.00	1,635.43	1,964.57
Council on Public Relations	52,700.00	87,206.56	(34,506.56)
Council on Medical Services	750.00	506.82	243.18
Council on Mental Health	1,700.00	786.55	913.45
President & Presidential Officers	21,700.00	16,291.25	5,408.75
AMA Delegates	22,000.00	23,748.76	(1,748.76)
MSNJ Auxiliary	8,195.00	7,494.12	700.88
Committee on Medical Education	40,800.00	20,558.41	20,241.59
Conference Groups	500.00	21.38	478.62
Membership Directory	26,000.00	71,548.98	(45,548.98)
Committee on Emergency Medical Care	10,500.00	10,757.94	(257.94)
Credentials	1,200.00	1,309.04	(109.04)
Committee on Medical Defense & Insurance	900.00	713.72	186.28
Membership Inquiry & Complaint Committee	1,000.00	570.25	429.75
Board of Trustees	10,000.00	5,039.48	4,960.52
Contingent	20,000.00	19,470.82	529.18
Judicial Council	1,000.00	108.12	891.88
Legal	13,000.00	162.28	12,837.72
College of Medicine & Dentistry Foundation	10,000.00	10,000.00	—0—
Medical Student Loan Fund	6,000.00	6,000.00	—0—
Authorized Reimbursement for Representatives to Meetings	5,000.00	5,508.09	(508.09)
Physicians' Relief Fund	6,000.00	—0—	6,000.00
Total Budget Expenditures	<u>\$858,914.00</u>	<u>\$781,593.21</u>	<u>\$77,320.79</u>



STATEMENT OF REVENUE AND EXPENDITURES  
MEDICAL JOURNAL

	Ten Months Ended March 31, 1977 (Unaudited)	Year Ended May 31, 1976 (Audited)
<b>Revenue:</b>		
Members' Subscriptions Earned	\$ 33,077.50	\$ 41,860.00
Advertising:		
United Media Associates	53,276.13	54,175.75
Local	16,644.86	18,610.55
Cooperative Rebate	—0—	1,234.55
Classified	772.35	556.45
Subscriptions & Extra Copies	1,998.33	2,068.89
Reprints—Net	4,042.98	326.86
<b>Total Revenue</b>	<u>\$109,812.15</u>	<u>\$118,833.05</u>
<b>Expenditures:</b>		
Publication	\$102,197.21	\$112,964.21
Salaries	35,177.20	34,446.15
Advertising Manager's Commission	6,151.92	9,224.34
Commissions—Local	10,162.16	7,687.86
Commissions—UMA	8,382.93	6,611.70
Discounts	1,227.74	1,168.92
Payroll Taxes	2,222.35	2,367.27
Insurance	25.00	25.00
Travel	456.33	691.81
Office	260.49	69.45
Bad Debts	175.00	1,044.50
<b>Total Expenditures</b>	<u>\$166,438.33</u>	<u>\$176,301.21</u>
Excess of Expenditures Over Revenue	<u>(\$ 56,626.18)</u>	<u>(\$ 57,468.16)</u>

BALANCE SHEET  
MEDICAL STUDENT LOAN FUND

	Ten Months Ended March 31, 1977 (Unaudited)	Year Ended May 31, 1976 (Audited)
<b>Assets</b>		
Cash (Page 17)	\$122,898.95	\$ 28,578.80
Certificates of Deposit	—0—	113,000.00
Notes Receivable—Secured by		
Life Insurance Policies Assigned	306,875.00	273,685.52
Loans Receivable—General Fund	46,500.00	54,000.00
Accrued Interest	—0—	509.14
Due from General Fund	10,538.00	—0—
<b>Fund Balance</b>	<u>\$486,811.95</u>	<u>\$469,773.46</u>

Note: The Fund balance includes \$7,612.00 designated as the Albert Barker Kump Memorial Grant and \$5,055.00 designated as the Joseph E. Mott Memorial Grant.

STATEMENT OF REVENUE AND FUND BALANCE  
MEDICAL STUDENT LOAN FUND

	Ten Months Ended March 31, 1977 (Unaudited)	Year Ended May 31, 1976 (Audited)
Revenue:		
Contributions:		
General	\$ 2,597.50	\$ 6,693.00
Albert Barker Kump Memorial Grant	—0—	250.00
Budget Appropriation—General Fund	6,000.00	6,000.00
Income from Investments	—0—	3,812.57
Income from Certificates of Deposit	4,125.37	2,723.50
Interest on Savings Account	877.93	—0—
Interest on Notes Receivable	215.69	270.72
Interest on Loans Receivable—General Fund	2,700.00	3,780.00
Commission Income—Fire Extinguisher Sales	522.00	—0—
Total Revenue	<u>\$ 17,038.49</u>	<u>\$ 23,529.79</u>
Fund Balance, Beginning	\$469,773.46	\$446,243.67
Fund Balance, Ending	<u><u>\$486,811.95</u></u>	<u><u>\$469,773.46</u></u>

SCHEDULE OF STATE ASSESSMENTS COLLECTED  
FOR THE TEN MONTHS ENDED MARCH 31, 1977  
(UNAUDITED)

County	1977 Net Dues	1976 Net Dues	Total Net State Assessments
Atlantic	\$ 19,680.00	\$ 3,575.00	\$ 23,255.00
Bergen	108,720.00	3,660.00	112,380.00
Burlington	23,040.00	1,240.00	24,280.00
Camden	53,240.00	1,320.00	54,560.00
Cape May	—0—	—0—	—0—
Cumberland	14,040.00	605.00	14,645.00
Essex	123,120.00	7,390.00	130,510.00
Gloucester	11,620.00	220.00	11,840.00
Hudson	32,760.00	5,230.00	37,990.00
Hunterdon	6,360.00	440.00	6,800.00
Mercer	16,100.00	8,910.00	25,010.00
Middlesex	52,500.00	5,655.00	58,155.00
Monmouth	43,940.00	4,950.00	48,890.00
Morris	47,340.00	2,090.00	49,430.00
Ocean	18,960.00	605.00	19,565.00
Passaic	68,640.00	1,450.00	70,090.00
Salem	4,080.00	—0—	4,080.00
Somerset	10,940.00	880.00	11,820.00
Sussex	7,200.00	220.00	7,420.00
Union	72,980.00	1,835.00	74,815.00
Warren	6,240.00	330.00	6,570.00
Total	<u><u>\$741,500.00</u></u>	<u><u>\$50,605.00</u></u>	<u><u>\$792,105.00</u></u>

RECONCILIATION OF STATE ASSESSMENT ACCOUNT  
FOR THE TEN MONTHS ENDED MARCH 31, 1977  
(UNAUDITED)

Unearned Assessments, June 1, 1976 .....			\$465,411.03
Collections—1976 Members' and Affiliate Members' Dues .....		\$ 50,605.00	
Less: Annual Meeting Assessment .....	\$ 1,118.75		
Medical Journal Assessment .....	<u>2,237.50</u>		
		\$ <u>3,356.25</u>	\$ 47,248.75
Collections—1977 Members' and Affiliate Members' Dues .....		\$741,500.00	
Less: Annual Meeting Assessment .....	\$15,420.00		
Medical Journal Assessment .....	<u>30,840.00</u>		
		\$ <u>46,260.00</u>	
		<u>\$695,240.00</u>	
Less: 1977 Assessments Applicable to Year Ending May 31, 1977— (\$695,240.00 x 7/12) .....		<u>\$405,556.69</u>	
			<u>\$289,683.31</u>
Earned Assessments for the Ten Months Ended March 31, 1977 .....			<u><u>\$802,343.09</u></u>

SCHEDULE OF AMA ASSESSMENTS COLLECTED  
FOR THE TEN MONTHS ENDED MARCH 31, 1977  
(UNAUDITED)

County	American Medical Association Dues
Atlantic .....	\$ 31,875.00
Bergen .....	134,875.00
Burlington .....	31,250.00
Camden .....	89,750.00
Cape May .....	—0—
Cumberland .....	16,000.00
Essex .....	202,250.00
Gloucester .....	18,750.00
Hudson .....	41,375.00
Hunterdon .....	20,670.00
Mercer .....	34,875.00
Middlesex .....	69,500.00
Monmouth .....	40,750.00
Morris .....	66,000.00
Ocean .....	20,000.00
Passaic .....	57,750.00
Salem .....	7,500.00
Somerset .....	16,500.00
Sussex .....	5,625.00
Union .....	99,875.00
Warren .....	9,750.00
Total .....	<u><u>\$1,014,920.00</u></u>



RECONCILIATION OF AMA ASSESSMENTS  
FOR THE TEN MONTHS ENDED MARCH 31, 1977  
(UNAUDITED)

	American Medical Association
Balance Payable, June 1, 1976	\$ 25,250.00
Assessments Collected per above Schedule	<u>1,014,920.00</u>
	\$1,040,170.00
Remitted to AMA	<u>1,012,170.00</u>
Balance Payable, March 31, 1977	<u><u>\$ 28,000.00</u></u>

SCHEDULE OF NJFHCE ASSESSMENTS COLLECTED  
FOR THE TEN MONTHS ENDED MARCH 31, 1977  
(UNAUDITED)

County	New Jersey Foundation for Health Care Evaluation
Atlantic	\$ 1,640.00
Bergen	9,060.00
Burlington	1,920.00
Camden	4,430.00
Cape May	— 0 —
Cumberland	1,170.00
Essex	10,230.00
Gloucester	960.00
Hudson	2,730.00
Hunterdon	530.00
Mercer	1,340.00
Middlesex	4,340.00
Monmouth	3,660.00
Morris	3,940.00
Ocean	1,580.00
Passaic	5,710.00
Salem	340.00
Somerset	910.00
Sussex	600.00
Union	6,070.00
Warren	<u>520.00</u>
Total	<u><u>\$61,680.00</u></u>

RECONCILIATION OF NJFHCE ASSESSMENTS  
FOR THE TEN MONTHS ENDED MARCH 31, 1977  
(UNAUDITED)

	New Jersey Foundation for Health Care Evaluation
Balance Payable, June 1, 1976	\$ — 0 —
Assessments Collected per above Schedule	<u>61,680.00</u>
	\$61,680.00
Remitted to New Jersey Foundation for Health Care Evaluation	<u>30,000.00</u>
Balance Payable, March 31, 1977	<u><u>\$31,680.00</u></u>

ANALYSIS OF PROFESSIONAL LIABILITY ACCOUNT  
MARCH 31, 1977  
(UNAUDITED)

Revenue:

Mandatory Assessment Collected— (Approximately 6136 @ \$200 each)	\$1,227,362.02	
Less: Refunds	<u>21,772.00</u>	
Net Revenue		\$1,205,590.02

Expenditures:

Cost of Collecting Mandatory Assessment	\$ 9,336.47	
Cost of Professional Liability Update	9,410.58	
Cost of Public Relations Advertising	46,538.51	
Cost of Professional Services	68,992.50	
Cost of American Health Systems Consultants	14,992.50	
Cost of Malpractice Litigation Meeting	2,453.80	
Cost of Printing MedicoLegal Seminar Booklets	3,897.00	
Other Expenditures	<u>2,049.96</u>	
Total Expenditures		<u>\$ 157,671.32</u>

Balance (Page 11)	<u>\$1,047,918.70</u>
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Note: Of the \$1,047,918.70 balance reflected above, the following additional cash outlays have been made, which are reflected in the balance sheet as assets; Notes Receivable NJSMUI \$107,093.03 and Notes Receivable Physicians \$15,600.00.

ANALYSIS OF CASH, CERTIFICATES OF DEPOSIT,  
INVESTMENTS AND INCOME THEREON  
MARCH 31, 1977  
(UNAUDITED)

	Cost	Yield	Interest Income
General Fund Cash			
New Jersey National Bank:			
Treasurer's General Checking (Overdraft)	(\$ 512,885.51)	—0—	—0—
Savings Account #01-19-174556	2,024,732.33	5-1/8%	\$28,477.63
Trenton Savings Fund:			
Certificate #10-8427	20,000.00	6%	996.67
Certificate #10-8428	20,000.00	6.75%	1,121.25
Petty Cash	<u>500.00</u>	—0—	—0—
Total General Fund Cash	<u>\$1,552,346.82</u>		
Income from General Fund Investments Redeemed During Period			<u>\$ 8,463.40</u>
Total Income (Page 11)			<u>\$39,058.95</u>

Portfolio Investments	Due Date	Maturity Value	Cost	Yield	Interest Income
U.S. Treasury Notes	7/31/77	\$ 40,000.00	\$ 40,000.00	7½%	\$ 2,500.00
Bank for Coops	4/4/77	50,000.00	49,796.88	7.7%	3,203.50
U.S. Treasury Note	6/30/78	60,000.00	59,943.75	6.875%	3,093.75
Federal Home Loan Bank	2/27/78	<u>40,000.00</u>	<u>40,075.00</u>	7¼%	926.38
		<u>\$190,000.00</u>	<u>\$189,815.63</u>		

Income from Portfolio Investments Redeemed During Period	<u>\$ 1,623.60</u>
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Total Income (Page 11)	<u>\$11,347.23</u>
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Medical Student Loan Fund Cash	Cost	Yield	Interest Income
New Jersey National Bank:			
Treasurer's Checking Account	\$ 21.02	—0—	\$ —0—
Savings Account #01-10-205566 (Page 14)	<u>122,877.93</u>	5-1/8%	877.93
	<u>\$122,898.95</u>		

Income from Investments Redeemed During Period (Page 14)	<u>4,125.37</u>
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Total Income	<u>\$ 5,003.30</u>
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# Board of Trustees

James S. Todd, M.D., Chairman, Ridgewood

(Reference Committee "A")

As the executive arm of the Medical Society between meetings of the House of Delegates, the Board of Trustees often is forced to make decisions not always popular with the membership, but almost invariably ratified when the House does meet. Increasingly, the Medical Society is pressured from many angles, and the Board's report mirrors the diversity of activity.

Among the most momentous decisions this year was the unanimous determination by the Board to protect the interests of its members by forming a captive professional liability insurance company. Without the diligence, sacrifice, and concern of the individual members of the Board, such an undertaking would have been impossible.

As a result of this activity, however, two things become clear. First, that the Board when faced with adversity will not shrink from the appropriate decision regardless of how arduous or unpopular that decision may be in its implementation. Foremost in the view of the Board is the well-being of the physicians of New Jersey and the assurance that these physicians may maintain the freedom to provide the best possible care to the people they serve.

Unfortunately, the second conclusion to be drawn from this year's activities is that despite our constitution as a democratic organization, there are those splinter groups who in their independent zeal and public pronouncements detract from the authority and influence of the entire Society. No one within the Medical Society organization fears disagreement or opposition. Indeed, spirited debate and questioning often sharpen the decision ultimately to be made. Once, however, a decision is democratically made, the members of the Society have a responsibility, whatever their individual feelings to preserve the unity of the profession. Those in the minority, if they feel strongly enough, have every right to work toward a change in Society

position, but only through the mechanisms of internal democracy. For a minority group publicly to oppose its parent organization or to divide its activities serves only to confirm the growing fragmentation of our profession. Such groups do not deserve, and will not get the attention they seek as long as they remain apart from the Society.

Continuing the custom of open meetings each county and specialty society is invited to attend all Board meetings. The attendance record is dismal; yet the reactive criticism some months down the road does a disservice to those who were there to make the decisions. Physicians cannot have it both ways. Either they become active within the Society or they must accept the deliberated opinions and actions.

If we learn nothing from the past, it should be that to be divided is to be conquered! Therefore, the Board reiterates its position that it is to serve the majority in the best interests of the majority, and will not be swayed by the dissonant cacophony of those unwilling to be part of an integrated organization. There no longer are any free rides.

The following specific reports attest amply to the diversity and magnitude of the problems facing our Society.

Filed (page Tr 128)

## ADMISSION OF OSTEOPATHIC PHYSICIANS TO THE MEDICAL SOCIETY OF NEW JERSEY

(Reference Committee "A")

The 1976 House of Delegates adopted, as amended, Resolution #1 calling upon the Board of Trustees to form a committee to investigate the legal, practical, and actuarial consequences of admitting osteopathic physicians to join The Medical Society of New Jersey.



At the direction of the Board of Trustees, the President appointed the following members of the Committee:

Sherman Garrison, M.D., Chairman  
Francis X. Keeley, M.D.  
Charles S. Krueger, M.D.  
Howard Lehr, M.D.  
Stephen Levine, M.D.

As charged by the House of Delegates, the Committee investigated the legal, practical, and actuarial consequences of admitting osteopathic physicians to membership in The Medical Society of New Jersey. The Committee's conclusions are as follows:

### **Legal Aspects**

1. The State Board of Medical Examiners has no concern with society memberships.

2. In order to enable doctors of osteopathy to be members of The Medical Society of New Jersey, it will be necessary to amend the Society's Constitution and Bylaws. The Committee suggests that the Constitution and Bylaws be changed to read:

Also eligible for membership are licensed physicians other than M.D.s who have had an AMA internship or residency or have a staff appointment at an allopathic hospital.

### **Practical Aspects**

1. It is the feeling of the Committee that of the less than 1,000 osteopaths in the State of New Jersey, those interested in joining The Medical Society of New Jersey will have very little impact and probably will be limited to those closely associated with allopathic hospitals.

2. The Committee feels also that The Medical Society of New Jersey should continue the cordial relationships maintained between the New Jersey Association of Osteopathic Physicians and Surgeons and The Medical Society of New Jersey in matters of mutual interest, and that the Society has no intention of actively soliciting members from the New Jersey Association of Osteopathic Physicians and Surgeons.

### **Actuarial Aspects**

1. As of September 3, 1976, our consultants advised that there is no predictable adverse impact on premiums.

2. In view of the completely unpredictable situation in this field, as of October 3, the Committee feels that the situation must be re-evaluated immediately prior to any action by the House of Delegates.

The Committee presented the following recommendations to the Board of Trustees for consideration:

1. That doctors of osteopathy be admitted to membership in The Medical Society of New Jersey.

2. That the Society's Constitution and Bylaws be amended to read:

Also eligible for membership are licensed physicians other than M.D.s who have had an AMA internship or residency or have a staff appointment at an allopathic hospital.

The Board amended recommendation #2 to read as follows:

That the Society's Constitution and Bylaws be so amended.

The Board also voted to take the following additional actions with respect to this subject: (1) to refer the recommendations to the Standing Committee on Revision of Constitution and Bylaws and (2) to disband the Special Committee to Study Admission of Osteopaths.

**Filed (page Tr 128)**

### **AMA MEMBERSHIP DRIVE**

(Reference Committee "A")

At its July 18 meeting, the Board of Trustees voted to urge all component societies to launch a vigorous and ongoing membership drive geared not only to recapture the "lost" AMA membership but to instill total unity in the profession.

**Filed (page Tr 128)**

### **ASSURANCE OF PROFESSIONAL COMPETENCE**

(Reference Committee "A")

At the last annual meeting, the House of Delegates adopted, as amended, Resolution #2 (Assurance of Professional Competence) submitted by the Camden County Medical Society. This Resolution directed that MSNJ emphasize the expulsion and delicensure of those physicians who would defame the good name of the profession. It also directed that the Resolution be introduced at the AMA Annual Convention in Dallas.

The AMA House of Delegates adopted the following substitute resolution:

RESOLVED, that the American Medical Association urge all peer review committees to make every effort to correct,

or refer to the appropriate disciplinary bodies, any physicians who do not meet accepted standards of professional conduct, including ethical behavior, or of professional performance.

**Filed (page Tr 128)**

**CHIROPRACTORS REQUESTING  
RADIOLOGICAL EXAMINATIONS**  
(Reference Committee "A")

In July, the State Board of Medical Examiners requested MSNJ's position on physicians refusing radiologic examinations for persons referred to them by chiropractors. Examinations refused dealt with: gallbladder, upper G.I., knee, thoracic spine, cervical spine, ankle, lumbosacral, and shoulder.

In reply to the State Board's letter, MSNJ's Board indicated that radiology is a recognized specialty within the medical profession. The radiologist, like any other physician, may determine to whom he will render his services, be it as a consultant or treating physician.

**Filed (page Tr 128)**

**INTERN AND RESIDENT COMMITTEES**  
(Reference Committee "A")

The Board of Trustees believes that the federation of organized medicine could be strengthened greatly in New Jersey by opening direct lines of communication between the component societies and the interns and residents in local hospitals. Component societies were urged by the Board to consider recommending to local hospital medical staffs that intern and resident committees be formed.

**Filed (page Tr 129)**

**PROCEDURAL GUIDELINES FOR HEALTH  
FACILITIES DEALING WITH COMATOSE PATIENTS**  
(Reference Committee "A")

The Commissioner of Health and the Attorney General had, on several occasions, convened a discussion group with representatives from the New Jersey Association of Osteopathic Physicians and Surgeons, the New Jersey Hospital Association, the Attorney General's Office,

the State Board of Medical Examiners, the Department of Health, and the Medical Society in order that a joint issuance and endorsement statement could be agreed upon for guidance in dealing with the care of comatose, non-cognitive patients. At the request of the Board, the Executive Committee reviewed and approved the guidelines as submitted.

**Filed (page Tr 129)**

**AD HOC COMMITTEE ON  
PROFESSIONAL LIABILITY**  
(Reference Committee "C")

Established by the House of Delegates in 1975, the Ad Hoc Committee on Professional Liability has been assigned the awesome task of solving the professional liability dilemma. Obviously, it has not, and probably never will accomplish that goal. The problem has too many facets to yield to one organization or to one approach.

The Committee is firmly convinced that there is both a professional and public responsibility involved. Perhaps failure to recognize the fact has hampered the progress in ameliorating the continuing crisis.

Statistics amply show that malpractice or incompetency account for a minority of the situations which produce suits. Injury without negligence under medical care, however, is not rare and will increase as more sophisticated techniques are developed. Currently, the only manner in which those patients harmed may recoup financial loss or damaged expectations is to sue the physician. If the American people wish to be compensated for the untoward events of medical care in the absence of negligence—and apparently they do—then it is their responsibility to develop an adequate compensation mechanism controlled and funded by the public. The profession can and will deal sternly with negligence, but it cannot support unfulfilled expectations.

Therefore, whatever the activity of the Committee, the membership must realize that only a basic change in societal attitude (or the bank-

ruptcy of the system) will eliminate what is now an intolerable and inequitable situation.

Patience and tolerance are required to avoid the pitfalls already evident as a result of hasty action by other groups. With rational equitable approaches and clear definition of responsibility, ultimately the professional liability will yield.

This year the Committee has worked in the following specific areas:

1. *Legislative:* In cooperation with other councils of the Society, caused to be introduced Senate Bills 1240 through 1246 which in the opinion of the Committee are necessary, but will not by themselves reverse rates' or claims' assertion. Further legislative activities are planned.

2. *Countersuits:* Have reviewed over 100 potential cases for countersuit, but as yet none has appeared of sufficient merit to pursue.

3. *Professional Education:* Multiple mailings to the membership and articles in *The Journal* have attempted to keep the membership informed and to highlight methods of avoiding lawsuits.

4. *Public Education:* Appropriated \$100,000 for public media use to inform the public of their stake in the professional liability problem.

5. *Alternative Programs:* The Committee continues to study alternatives to the present system and modifications which more clearly will define responsibility in medical injury.

6. *Prevention of Malpractice:* The Committee will work closely with the New Jersey State Medical Underwriters, Inc. to develop risk prevention and claims' management programs.

**Filed (page Tr 132)**

ASSIGNMENT OF BENEFITS  
(Reference Committee "C")

Following the close of the 1976 Annual Meeting, Resolution #4 (Assignment of Benefits) was

referred to Medical-Surgical Plan of New Jersey for consideration. Medical-Surgical Plan of New Jersey has replied . . .

Resolution #4 petitions Blue Shield of New Jersey to change its contract to allow assignment of benefits to non-participating physicians. Our committee reviewed background information which indicates that the principle of direct payment to Participating Physicians and direct payment to subscribers for services rendered by non-participating physicians has repeatedly been supported by the House of Delegates of The Medical Society of New Jersey, both before and after the 1964 date mentioned in the resolutions.

The Medical Society's Board of Trustees is similarly on record.

Blue Shield's Board noted that Participating Physicians have agreed to accept Plan payment as payment-in-full for eligible services rendered to subscribers whose incomes are below specified levels, and quoting from a statement by MSNJ's legal counsel . . . "participating physicians, in effect, make a sacrifice for the benefit of all subscribers which is not made by non-participating physicians . . . . . therefore, it would be improper for the non-participating physician to receive all the benefits received by the participating physician . . . .".

If non-participating physicians *were* paid directly, there would be no practical reason to participate, and eligible subscribers would be deprived of service benefits—that feature of Blue Shield which sets it apart from commercial insurance carriers. Direct payment is readily available to all who agree to participate.

In the last three years the Plan has been able to promote the 750 and UCR contracts instead of the old 500 contract and the majority of our contracts are now in the 750 and UCR category. Groups are willing to pay the additional premium for the 750 and UCR contracts which pay higher fees to the physicians only if we can assure them service benefits from a large group of Participating Physicians. They would not buy these contracts if we accepted assignments and weakened the service benefit part of our program.

After careful study, and for the above reasons, the Blue Shield Board regrets that it cannot implement the suggestions contained in Resolution #4.

**Filed (page Tr 132)**

BLUE SHIELD CLAIM FORM  
(Reference Committee "C")

Following the close of the 1976 Annual Meeting, Resolution #24 (Blue Shield Claim Form) was referred to Medical-Surgical Plan of New Jersey for consideration. Medical-Surgical Plan of New Jersey has replied . . .

Resolution #24 calls on Blue Shield of New Jersey to accept a Health Insurance Council (HIC) form in lieu of its own claim forms.



To process its claims in a manner equitable to physicians and Blue Shield subscribers alike, the Plan needs certain information. The HIC form currently provides no space for several necessary items and permits no alteration of the form whatsoever. The following considerations cannot be ignored:

(a) As a result of New Jersey's no-fault law, Blue Shield complied with the Commissioner of Insurance's request and does not pay for any automobile accident-related injuries. Therefore, we must ask whether or not an injury is related to an automobile accident.

(b) In accordance with New Jersey's laboratory disclosure law, a patient or third-party payor is entitled to know the name of the laboratory where the services were performed and the actual, itemized charges paid or payable to the laboratory.

(c) Administration of Blue Shield of New Jersey's contracts require:

- (1) A statement as to whether all prenatal care was provided by the same physician.
- (2) The names of any other physicians rendering care during hospitalization.
- (3) A statement that services were personally performed.

In addition, certain objections to the Blue Shield claim form expressed in Resolution #24 are simply not valid. Overall, the Blue Shield of New Jersey Service Report requires less information than the HIC form, which requires certain items not asked for on the Blue Shield form.

(a) Date of first examination

(b) Preexistence of symptoms

(c) Disability information (5 dates)

The intent of Resolution #24 to cut down the increasing flow of insurance paper work to physicians is understandable and reasonable. However, the use of the HIC form will not accomplish this intent and may indeed increase the paper work because the Plan would have to contact the physician for additional information.

After careful study, and for the above reasons, the Blue Shield Board regrets that it cannot implement the suggestions contained in Resolution #24.

**Filed (page Tr 132)**

#### EXPULSION OF UNQUALIFIED PHYSICIANS TESTIFYING AS EXPERT WITNESSES

(Reference Committee "C")

The Board voted to support a resolution, adopted by the Pennsylvania Medical Society, calling for the expulsion of unqualified physicians testifying as expert witnesses.

Pennsylvania's official definition of expert witness is: "Expert witness must have basic

educational and professional knowledge as a general foundation for his testimony, and in addition, have current personal experience and practical familiarity with the problems that are being considered and be actively engaged in the practice of the medical subject under discussion."

**Endorsed and referred to the AMA Delegation (page Tr 132)**

#### OCHAMPUS

(Reference Committee "C")

The Federal Government has changed fiscal intermediaries for the OCHAMPUS Program in New Jersey from Blue Shield of New Jersey to the Virginia Blue Shield Plan. Review committee procedures were agreed upon and maintained with Blue Shield of New Jersey, however, no agreement has been entered into with Virginia Blue Shield. Currently, requests are on file from the government for review by MSNJ.

The Board empowered the Executive Director to direct the inquiries to the county level.

**Filed (page Tr 133)**

#### HIGH FEES FOR PARTICIPATION IN CONTINUING MEDICAL EDUCATION PROGRAMS (Reference Committee "D")

At the request of the 1976 House of Delegates, the New Jersey Delegation introduced Resolution #23 (High Fees for Participation in Continuing Medical Education Programs) at the AMA Annual Convention in Dallas.

Resolution #23 urged that the AMA oppose excessive fees for continuing medical educational programs and that the AMA prevail upon national accrediting agencies to require accredited program sponsors to indicate whether programs are conducted on a profit or non-profit basis. The resolution also requires sponsors of AMA accredited programs to make a similar declaration.

The AMA Reference Committee felt that the issue of the cost of continuing medical education is complex and deserving of thorough re-

view. The Resolution was referred to the AMA Board of Trustees.

**Filed (page Tr 134)**

**CAT SCANNER**  
(Reference Committee "F")

New Jersey State Senators James A. Wallwork (D-Essex) and Wayne Dumont (R-Warren) have introduced S-3022, which would make it practically impossible for private physicians to purchase a CAT scanner by requiring them to apply for and receive a certificate of need from the State Commissioner of Health.

The proposed bill is an amendment to a law which requires hospitals and health care facilities to be certified by the State. The law was initially designed for hospitals, not for private physicians.

The Board empowered the Executive Committee to institute suit, if and when it becomes necessary.

**Filed (page Tr 136)**

**MEDICAL ASSISTANCE ADVISORY COUNCIL**  
(Reference Committee "F")

The Medical Assistance Advisory Council approved a resolution petitioning the Legislature of the State of New Jersey to provide sufficient funding to restore adequate fees for the Medicaid providers by restoring \$12,000,000 (\$6 million in State funds and \$6 million in Federal funds) to the Medicaid 1975-76 budget.

The Board voted to support the resolution. The Division of Medical Assistance subsequently acted favorably on this matter.

**Filed (page Tr 136)**

**RELATIVE VALUE INDEX**  
(Reference Committee "F")

The New Jersey State Society of Anesthesiologists requested MSNJ to support a resolution to be submitted by the Oregon State Medical Society to the AMA House of Delegates in December. The resolution directed the AMA to help defend against legal attacks on the use

of the relative value studies and to promote legislative support for relative value studies.

The resolution was referred to the New Jersey Delegation to the AMA for support. At the AMA Clinical Convention held in Philadelphia, the House of Delegates voted to refer the resolution to the AMA Board of Trustees.

**Filed (page Tr 137)**

**AD HOC COMMITTEE ON BLOOD PROCUREMENT**  
(Reference Committee "G")

Created by the Board of Trustees in 1975 in response to a State Government Commission report critical of the State's blood banking situation, this Ad Hoc Committee further studied the situation and reached these somewhat frightening but basic conclusions:

1. Blood procurement in New Jersey rests on the shaky tripod of voluntary community blood banks, hospital-based procurement centers, and Red Cross Blood Centers.
2. There is little, if any, cooperation or communication between these groups.
3. The New Jersey Blood Bank Association is impotent due to parochial reluctance to deal with statewide problems.
4. Blood transfer within the State is far more cumbersome and expensive than it should be, and in some instances it may be more advantageous to ship blood out of State than to transfer it within the State.
5. There are no uniform blood accounting procedures in existence. The cost of blood in the State varies by as much as 200 percent, and without question income from this source is sometimes used to offset operating costs in other areas of health facilities.
6. There is no unified blood procurement program, and pirating of donor areas is common. Replacement fees continue to cause controversy, yet when eliminated have not resulted in a decline of cost or an increase in blood supply.

7. The creation of the American Blood Commission and its intent toward regionalization has further confused the issue and encouraged already existing blood centers more firmly and parochially to establish their territory.

8. The split between the American Association of Blood Banks and the American Red Cross is polarizing the blood system nationwide, and has widened further the dispute concerning public and personal responsibility.

Reluctantly, but inexorably, the Committee came to the conclusion that the task of straightening out what is admittedly a confused and inequitable situation was beyond its ability, and probably beyond that of The Medical Society of New Jersey. Three alternatives are available:

1. Commit the prestige and resources of the Medical Society to act as a catalyst and ombudsman in developing an integrated self-supporting blood procurement system for New Jersey.

**Approved (page Tr 139)**

2. Encourage the State Department of Health, which is responsible for blood supply and its use, to issue the regulations necessary to produce a self-supporting, adequate, and equitable supply of blood.

**Disapproved (page Tr 139)**

3. Allow the present system to continue, relying upon private enterprise ultimately to adjust the system.

**Approved (page Tr 139)**

The Committee leaves it to the House of Delegates to determine which alternative they wish the Society to pursue.

**Filed (page Tr 139)**

## Supplemental Report #1

### AD HOC COMMITTEE ON PROFESSIONAL LIABILITY

James S. Todd, M.D., Chairman, Ridgewood  
(Reference Committee "C")

At its meeting on March 30, 1977, the Ad Hoc Committee on Professional Liability reviewed

the current status of the Medical Society's program relating to liability control. Among the items discussed were: limits on awards; compensation funds; structured payments; physician discipline and education; public education; newsletter; risk management; and screening panels.

The Committee decided that it would pursue investigation of the mandatory use of pre-trial screening panels and the development of a patient compensation fund, supported publicly, which would respond to screening panel decisions where no negligence was involved.

The Committee believes that the program of structured payments and risk management, best can be developed by the New Jersey Underwriters, Inc.

Public education through the media is an ongoing program with the Council on Public Relations and thus far seems to be relatively effective.

It also decided to attempt negotiations with the State Board of Medical Examiners to develop medical inquiry boards, composed entirely of physicians, who initially would investigate allegations against physicians and make recommendations to the State Board of Medical Examiners, thereby affording the physician a more equitable and speedy resolution of his problems.

The need for physician education in relation to circumstances predisposing to liability claims was reaffirmed and the Committee plans to produce regular newsletters highlighting those areas most often resulting in suits.

The Committee noted that 6,109 members of The Medical Society of New Jersey have contributed their \$200 mandatory professional liability assessment. While the Bylaws provide that a physician who is in arrears on any assessments shall have his membership terminated at the end of the succeeding fiscal year, the Committee was sympathetic to the many emotional and economic considerations which may have prevented the remainder of the



Society from contributing. The Committee believes that it is a privilege and a benefit to belong to The Medical Society of New Jersey, and that the strength of the organization is derived from total participation in the absence of odious coercion.

#### **Recommendations**

(1) That the \$200 mandatory assessment continue in effect for all members of the Society, as well as new members of the Society, but that the payment of this assessment not be demanded by any specific date. Rather, it should be left to the individual conscience and responsibility of the member to determine how best to fulfill his obligations.

**Disapproved. See report of Reference Committee "B." (page Tr 131)**

The Ad Hoc Committee recognized that with the formation of the Medical Inter-Insurance

Exchange of New Jersey, the Standing Committee on Medical Defense and Insurance had removed from it a large portion of its previous responsibilities.

(2) That since the membership and activities of the Committee on Medical Defense and Insurance and the Ad Hoc Committee on Professional Liability, to a large measure, parallel one another, it is the recommendation of the Ad Hoc Committee on Professional Liability that the Committee disband and that its responsibilities and membership be assigned to work with the Committee on Medical Defense and Insurance, utilizing the services of the Council on Public Relations and the Council on Legislation as needed.

**Approved (page Tr 132)**

**Filed (page Tr 132)**

### **1976 TRANSACTIONS**

At its first session on Saturday, May 14, 1977, the House of Delegates approved the Transactions of the 1976 House of Delegates as published in the August 1976 issue of *The Journal*, and the Transactions of the Special Session of the House of Delegates, December 1, 1976, as published in the January 1977 issue, and distributed to the membership.

# Judicial Council

Albert F. Moriconi, M.D., Chairman, Trenton  
(Reference Committee "A")

The files of the Judicial Council continue to reflect overall efficiency in the statewide operation of the judicial mechanism. The Council has continued its precedent of scheduling meetings on the fourth Sunday of each month. However, the volume of business requiring its attention has necessitated fewer meetings this year.

From the official findings, the Council here presents a summary of its operations and those of county judicial committees for the period from June 8, 1976 to March 21, 1977.

## BY JUDICIAL COMMITTEES

Complaints reported as disposed of . . . . .	42
Alleging:	
Dissatisfaction concerning fees . . . . .	29
Dissatisfaction concerning medical procedures . . . . .	5
Unprofessional conduct . . . . .	5
Dissatisfaction concerning professional ethics . . . . .	3

## BY JUDICIAL COUNCIL

Meetings held . . . . .	3
Official communications acted upon . . . . .	45
Appeal hearings requested . . . . .	6
Appeal hearings granted . . . . .	0
Formal opinions rendered . . . . .	0
Formal opinions amended . . . . .	1

ACCEPTABILITY OF A PHYSICIAN'S INSCRIBING  
THE FOLLOWING STATEMENT ON MEDICAL  
BILLS SUBMITTED TO PATIENTS:  
"BILL IS PAYABLE ON PRESENTATION.  
INSURANCE FORMS EXECUTED ONLY WHEN  
ACCOUNT IS PAID IN FULL."

(ADOPTED FEBRUARY 28, 1971 AS MSNJ  
OPINION #66)

The foregoing amended Opinion (MSNJ Opinion #66) is presented in full at the conclusion of this report.

It is the Council's experience that the most common complaint concerns fees or the misunderstanding of what was to be expected in the treatment of a patient. Wherever possible, it would

seem wise to have a clear understanding between physician and patient regarding these considerations before treatment is undertaken.

The Council takes this opportunity to emphasize that decisions of judicial committees of component societies are binding upon all members. The judicial committee of each component society, in the enforcement of its findings duly arrived at, has the power to censure, suspend, or expel any member of its society for just cause.

## REVISED OPINION #66

OPINION OF THE JUDICIAL COUNCIL OF THE  
MEDICAL SOCIETY OF NEW JERSEY  
CONCERNING THE ACCEPTABILITY OF A  
PHYSICIAN'S INSCRIBING THE FOLLOWING  
STATEMENT ON MEDICAL BILLS SUBMITTED TO  
PATIENTS: "BILL IS PAYABLE ON  
PRESENTATION. INSURANCE FORMS EXECUTED  
ONLY WHEN ACCOUNT IS PAID IN FULL."

OFFICIALLY ADOPTED FEBRUARY 28, 1971

This request for an opinion from the Executive Director of a component society in the name of the Chairman of the Judicial Committee was directed to the Council's attention. In considering the question as to whether it was ethical to inscribe on bills submitted to patients: "Bill is payable on presentation. Insurance forms executed only when account is paid in full," the Council rendered the following opinion:

The report of the Judicial Council of the American Medical Association, adopted by the AMA House of Delegates at the Clinical Convention in Boston in 1970, contained the following relevant paragraphs:

Some physicians seem to believe that the practices of business enterprises should be utilized by physicians in order to "encourage prompt attention to medical accounts." They ask, "why

shouldn't we be paid as soon as the dry goods store, the grocer, or the TV serviceman?"

Ideally, the physician should be paid promptly. If the physician is not paid as promptly as other creditors he should recall that he is a professional man, with all the perquisites that the term implies. Our patients in large number carry insurance to cover the cost of medical services. (They do not insure payment of the cost of other professional or business services to any notable extent.) Governmental programs have been instituted and are being developed continually to provide payment for medical care to those who are unable to provide this payment.

The Judicial Council, in light of the foregoing citation, points out:

1. That preemptory demand for immediate payment of bills rendered to patients by physicians is a practice incompatible with the dignity of medicine as a profession.
2. To insist routinely on payment from a patient before necessary insurance forms will be completed is to disregard the issue of a given patient's inability to pay from personal funds.
3. The Judicial Council of the American Medical Association has formally declared:

"The attending physician should complete without charge the appropriate 'simplified' Health Insurance Council forms approved by the Council (AMA) on Medical Service, and similar insurance claim forms as part of the physician's service to the patient to enable him to receive his benefits.

For all the foregoing reasons, the Judicial Council declares that the practice in question is not permissible because it offends the accepted standards of professional conduct.

Filed (page Tr 129)

## Supplemental Report #1

### OPINION OF THE JUDICIAL COUNCIL RE ETHICALITY OF PHYSICIAN'S LISTING A SEPARATE CHARGE FOR PROFESSIONAL LIABILITY INSURANCE ON THEIR BILLING STATEMENTS.

OFFICIALLY ADOPTED MARCH 27, 1977

It has been brought to the attention of the Judicial Council that a number of physicians are including in their billing statements a separate line item and charge for professional liability insurance.

The Council believes that such a practice is in poor taste, unethical, and indeed could be quite misleading.

Professional liability insurance, like employees' salaries, office rental, utility bills, transportation and equipment charges, and so on, is a cost factor in the conduct of medical practice. If the costs of practice have risen to the point where the physician is not being adequately compensated for his services, then he should indeed increase his fees to address that fact. By using a line charge method the physician indicates that the money in question is indeed being paid for insurance. The Council finds that it is impossible to have such an accurate accounting system in a medical practice since the number of patients treated or procedures performed never can be projected accurately. Unless all of the money collected is paid for liability insurance the billing system is misleading.

The Council is well aware of the need to educate the public as to the cost of professional liability insurance, but for the foregoing reasons finds the method under consideration "unethical."

Filed (page Tr 129)



## Executive Director

Vincent A. Maressa, Trenton  
(Reference Committee "A")

In my first Annual Report to this House of Delegates (1974), I indicated that if The Medical Society of New Jersey and organized medicine were to survive, they must become responsive to the needs of the membership. Those needs as most frequently expressed are organizational, scientific, economic, political and legislative effectiveness.

This House is well on the way to addressing the organizational goal. You have before you a Constitution and Bylaws which, if adopted, will afford the membership stability and flexibility. Your Committee on Constitution and Bylaws in presenting this complete document to you has merged the best of the past and innovated to meet future need. It also has avoided the pitfall of attempting to codify an everyday procedural manual.

The scientific need of the membership is being met by the Scientific Sessions and your Committee on Medical Education working in close alliance with hospital and medical staffs, the College of Medicine and Dentistry of New Jersey, the Academy of Medicine, and the various specialty societies.

Economic needs are being managed through the Council on Medical Services and the Board of Trustees through aggressive actions on issues such as Certificate of Need, CAT Scanners, and Comprehensive Health Planning. Additionally, the Committee on Medical Defense and Insurance continues its comprehensive and dedicated efforts. The creation of the New Jersey State Medical Underwriters, Inc. and the Medical Inter-Insurance Exchange of New Jersey presents almost unlimited potential for benefits to the practicing physician as long as we continue to strive for a sensible and realis-

tic balance among the essentials of stability, conservatism, and innovation.

The last area—political and legislative effectiveness—is one of the least manageable and most volatile. Last year we gave you our thoughts on what the Society ought to do to achieve the level of performance its members desire. We received no comments so we will again place the concept before you.

"Clearly, the time has come for The Medical Society of New Jersey to constrict its legislative aspirations within realistic parameters. An area that deserves initial concern is that of the licensure of ancillary professionals and/or the expansion of their permitted functions. The Society is often criticized in this type of activity as being 'opposed to everything,' 'selfish,' 'interested in monopolizing the health-care field to preserve its own economic empire.' The end result is a torrent of diatribe, invective, hostility, and frustration.

"Perhaps you should consider a posture that the Legislature can license whomever and whatever it so desires. If the medical doctor is, as we assume, the most diversified, well-educated, scientifically expert, technically competent, and professionally astute practitioner of the healing art, what do you have to fear in a free and openly competitive market? Sooner than many anticipate, the consumer will, I suspect, place his faith and allegiance with those practitioners truly deserving of it. The economic benefits will, perforce, naturally follow.

"Reasonable comment from responsible sources is appreciated and solicited."

Filed (page Tr 129)

# Annual Meeting

**James E. D. Gardam, M.D., Chairman, Millville**

(Reference Committee "H")

The 211th Annual Meeting of The Medical Society of New Jersey is being held in Atlantic City, after two years' experience in other locations. This meeting includes the Third Annual Governor's Conference. This Conference is designed to provide the membership with a program concerned with the ethical and philosophic aspects and social and economic impacts of the practice of medicine. This program has been well attended and its continuation is recommended.

The 211th meeting is held in conjunction with the 50th anniversary of MSNJ's Auxiliary, and in preparation there has been close liaison with the Auxiliary. A representative of the Auxiliary is invited to participate in Committee deliberations. It is recommended that in the future there be continued close cooperation with the Auxiliary for the interplanning and development of the Annual Meeting.

This meeting includes an innovation—the First Annual Prayer Breakfast, which is an indication of the concern of the Society for the ethical, moral, and philosophical aspects of medical practice. A reporting session of the AMA Delegates has been continued to permit individual membership participation in the determination of policy.

There have been some changes made in the ceremonies coincident with the opening of the House of Delegates. These changes have been designed to provide a more formal and dignified atmosphere for the conduct of the Society's business.

Because of recent developments concerning Atlantic City's future, the Annual Meeting Committee has planned an additional session of Reverence Committee "H" during the Annual Meeting. This will permit further discussion of future sites for the Annual Meeting during the regular session of the reference committee and adequate time for a final recommendation to

the House of Delegates after review of experience derived from the actual condition of the 211th Annual Meeting.

The Committee wishes to acknowledge with thanks the contributions of Mead Johnson Laboratories and Smith Kline & French Laboratories as official patrons of the Educational Programs; the American Association of Medical Assistants, State of New Jersey, Inc., for the Message Center; Roche Laboratories for sponsoring the Motion Picture Theatre; Prudential Insurance Company of America for sponsoring the Coffee Lounge; and each of the technical exhibitors. The scientific and informational exhibitors contribute substantially to the success of this meeting and their participation is commended.

The Chairman wishes to commend and thank the members of his Committee who worked so diligently to provide a meeting that would appeal to the widespread interests of the membership. The Chairman also wishes to commend Mrs. Walton, Mrs. Walsh, and the entire Medical Society staff for their cooperation and effort.

## Recommendations

1. That Reference Committee "H" and the House of Delegates provide guidance to the Committee concerning the site of the 212th Annual Meeting (1978).

**Approved (page Tr 140)**

2. That the Governor's Conference, AMA Delegates' reporting session, and the Prayer Breakfast be continued.

**Approved (page Tr 140)**

3. That the Reference Committee and House of Delegates indicate to the Committee on Annual Meeting any other changes in the An-

nual Meeting format that appear to be desirable.

**Approved (page Tr 140)**

**Filed (page Tr 140)**

**By action of the House decision concerning the dates and site of the 1978 Annual Meeting was referred to the Board of Trustees.**

### SCIENTIFIC PROGRAM

James E.D. Gardam, M.D., Chairman, Millville

At the 211th Annual Meeting, 51 member-speakers and 23 guest-speakers will present scientific papers at 18 scientific sessions. The Third Annual Governor's Conference on Government and Medicine will be held on Saturday morning during the convention. In addition, the Annual Spencer T. Snedecor Trauma Oration will be presented; and the New Jersey Chapter, American College of Chest Physicians again will sponsor the Annual Selman A. Waksman Lecture.

Through the Academy of Medicine of New Jersey, hour-for-hour credit for all of the 1977 Scientific Sessions and the Governor's Conference has been approved for Category I, AMA Physician's Recognition Award, Continuing Medical Education Program, MSNJ; and the four sessions being sponsored by MSNJ's Section on Family Practice have been approved for two hours each of Prescribed Credits by the American Academy of Family Physicians.

The Chairman wishes to express his sincere appreciation to the Annual Meeting Committee members, scientific section officers, and to the representatives of the specialty societies who contributed to the development and implementation of the scientific program.

The excellence of the scientific programs bears out the opinion that co-sponsorship by the New Jersey Specialty Societies should be continued in future years.

**Filed (page Tr 141)**

## Honorary Membership

**Charles H. Calvin, M.D., Chairman, Edison**  
(Reference Committee "H")

No nominations were submitted this year to the Committee. Consequently, no meetings were

held during this administrative year.

**Filed (page Tr 141)**



# Credentials

Arthur Bernstein, M.D., Chairman, Maplewood

(Reference Committee "A")

The Committee on Credentials, throughout the year, reviewed and acted upon membership applications and their supporting credentials as submitted through the component societies.

The following statistical breakdown reflects the Committee's activities during the period March 1, 1976 to February 28, 1977.

	*Associate	Active	Grand Total
Received			
*Interns	53		
*Residents	75		
Total	128	850	978

	*Associate	Active	Grand Total
Reviewed and found:			
(a) Satisfactory			
*Interns	53		
*Residents	74		
Subtotal	127	783	910
(b) Unsatisfactory	0	0	0

Pending:

*Interns	0		
*Residents	1		
Subtotal	1	67	68
Total	128	850	978

\*Associate membership (non-licensed in New Jersey) designates interns and residents.

The Committee extends appreciation to the secretaries of component societies, and to those who assist them, for their cooperation in processing membership applications. It would be especially helpful to the Credentials Committee of MSNJ if those who process credentials in the component societies would call specific attention to any deficiencies or questionable data being submitted on the application form. This procedure will help insure more accurate and speedy evaluation of credentials.

Filed (page Tr 129)

# Finance and Budget

Louis G. McAfoos, Jr., M.D., Chairman, Camden

(Reference Committee "B")

A review of the expenses of the first ten months of the current administrative (fiscal) year and an estimation of the expenses for the final two months indicate that the individual budget accounts are sound.

## THE JOURNAL AND ANNUAL MEETING EXPENSE

The (net) *Journal* Deficit is anticipated to be higher, even though this will be the fifth year that a per capita assessment designated for each member's *Journal* subscription rate will be applied. The dues allocation to *The Journal* will be \$5 per member for 1977 as it was for 1976 or one half of the yearly subscription rate.

The anticipated increase in the net deficit can be attributed to several factors: (1) National advertising revenue has risen for the second time in years; however, it has not been sufficient to absorb the increased publishing costs. As of January 1, 1977, a new printer has been engaged and with the use of lighter weight inside paper stock and economical web presses, it is expected that production costs should level off. (2) Non-printing costs centering on personnel salaries, taxes, commissions, office expenses, and insurance can be held accountable for the remainder of the deficit increase. The experience in 1977 has been consistent for all state journals.

Your Committee recommended, with the concurrence of the Board of Trustees, that the 1978 assessment include a \$5 and \$2.50 per capita assessment designated respectively for each member's *Journal* subscription rate, and Annual Meeting registration rate, that the full amounts realized as of May 31, 1978 be applied in 1978, and that the Committee on Finance and Budget be called upon to review these allocations annually.

Your Committee was cognizant of the fact that the above action will not discharge completely the deficits incurred each year in these two accounts. Nevertheless, the net deficit in each account will be considerably less and will be charged to the unexpended balance of the fiscal budget and/or the balance of the General Fund (Unappropriated).

#### COUNCIL ON PUBLIC RELATIONS

Your Committee has approved, with the concurrence of the Board of Trustees, the addition of \$65,000 in the budget of the Council on Public Relations for 1977-78 to cover expanded public relations programs.

#### PRESIDENT AND PRESIDENTIAL OFFICERS

Your Committee has approved, with the concurrence of the Board of Trustees, the inclusion of \$6,700 in the budget of the President and Presidential Officers to cover a per diem of \$100 for those members of the Executive Committee and/or those officially representing The Medical Society of New Jersey, approved by the Executive Committee, for the time and effort demanded over and above travel expense. It is to reimburse the approved official representing MSNJ for loss of his practice while performing a specific function.

#### MEDICAL EDUCATION AND THE ACADEMY OF MEDICINE OF NEW JERSEY

Your Committee again has approved, with the concurrence of the Board of Trustees, the inclusion of \$25,000 in the budget of the Committee on Medical Education for 1977-78 for the Academy of Medicine of New Jersey for

post-graduate educational programs and activities, with the continued proviso that the Committee on Medical Education, with the concurrence of the Board of Trustees, be empowered to expend up to this amount in the course of the administrative (fiscal) year on the basis of need reflected in the 1977-78 fiscal report to be submitted by the Academy of Medicine of New Jersey to the Committee on Finance and Budget.

#### EMERGENCY MEDICAL CARE AND INTER-AGENCY COMMISSION ON EMERGENCY MEDICAL CARE

Your Committee has approved, with the concurrence of the Board of Trustees, the inclusion of \$10,000, for the third year, in the budget of the Committee on Emergency Medical Care for 1977-78 for the Inter-Agency Commission on Emergency Medical Care. The foregoing does not represent any increase to the 1977-78 budget.

#### PROFESSIONAL LIABILITY FUND

Your Committee has approved, with the concurrence of the Board of Trustees, that up to 2/3 of the Professional Liability Fund be invested in higher yielding investments extending out two (2) years. The type of investment would include saving certificates of deposit, U.S. Treasury bills, bank debentures, and other U.S. government secured agencies. Your Committee has further approved, with the concurrence of the Board of Trustees, that all accrued interest earned on the Professional Liability Fund be credited to that account. For the detailed accounting on the Professional Liability Fund you are requested to review the Treasurer's Report.

#### NEW JERSEY FOUNDATION FOR HEALTH CARE EVALUATION

Your Committee has approved, with the concurrence of the Board of Trustees, the proposed 1977-78 Budget prepared by the Finance Committee of the New Jersey Foundation for Health Care Evaluation. The budget totals \$162,663.

## 1978 ASSESSMENT

The computation of the unappropriated General Fund balance at the close of the 1976-77 fiscal year is estimated at \$296,254.89—48.1% above the \$200,000 sum approved, with the concurrence of the Board of Trustees as the desired minimal surplus.

In accordance with Chapter X of the Bylaws, the dues year is January 1 to December 31, and the fiscal year is June 1 to May 31. The administrative year including the budget, which controls expenditures, is based on the fiscal year. It therefore becomes necessary to apportion the 1977 and 1978 per capita assessment to the 1977-78 fiscal year on the basis of 7/12 of the 1977 assessment for the new fiscal year soon to commence (June 1, 1977) and 5/12 of the 1978 assessment for the latter part of that fiscal year starting January 1, 1978.

The following is the Computation of the General Fund Balance and the Determination of the 1978 Assessment: (Unappropriated Fund Balance)

Proposed Budget for 1977-78	\$1,022,904.00
7/12 of 1977 assessment applicable to 1977-78 budget	512,423.33
Amount to be raised by 5/12 of 1978 assessment	<u>\$ 510,480.67</u>
 \$147.97 x 8,280 members paid =	
\$1,225,191.60 x 5/12	\$ 510,496.50
Amount to be raised with General Fund Balance over \$200,000 applied to budget excess at 5/31/77, estimated	\$ 96,254.89
Amount needed to reduce the per capita assessment from \$147.97 to \$120	<u>\$ 96,480.67</u>
Remainder of General Fund Balance in excess of \$200,000	\$ (225.78)
Add the required General Fund Balance	<u>\$ 200,000.00</u>
Estimated adjusted General Fund Balance at 5/31/77	<u>\$ 199,774.22</u>
 \$120 x 8,280 members paid = \$993,600	
x 5/12	\$ 414,000.00
plus the amount raised from General Fund Balance	<u>\$ 96,480.67</u>
Amount to be raised to meet 5/12 requirement	<u>\$ 510,480.67</u>

For each \$1,000 increase in the proposed budget add 29¢ to assessment.

For each \$1,000 decrease in the proposed budget subtract 29¢ from assessment.

## 1977-78 BUDGET

The proposed budget for 1977-78 totals \$1,022,904. It is the opinion of the Committee that the budget adequately should provide the necessary funds for the efficient operation of the Society's business during the coming year. It is not to be assumed that all sums budgeted necessarily will be utilized.

As requested by the House of Delegates, your Committee is listing explanatory footnotes on accounts which show a marked difference between current and proposed budgets.

Your Committee has included, as an addendum, the 1977 dues' assessment for the fifty-two state societies as published by the AMA.

### Recommendations

(1) That the Budget for 1977-78 be adopted in the total sum of \$1,022,904.

**Approved (page Tr 130)**

(2) That the 1978 assessment be adopted at \$120 per capita, with no provision for a contribution to AMA-ERF. The dues' assessment will cover a budget allocation to the Academy of Medicine of New Jersey, for the ninth consecutive year, which eliminates the need for special assessment therefor. The dues' assessment will also cover a budget allocation, for the fourth year, to the Inter-Agency Commission on Emergency Medical Care and a budget allocation, for the second year, to the Foundation of the College of Medicine and Dentistry of New Jersey. That of the \$120 per capita assessment, \$5 and \$2.50 be designated respectively for the member's *Journal* subscription and Annual Meeting registration; and that the full amounts realized as of May 31, 1978, be applied in 1978.

**Approved (page Tr 130)**

(3) That a special assessment be adopted at \$10 per capita, to serve as a grant to the New Jersey Foundation for Health Care Evaluation; that this special per capita assessment be set in



addition to and not as part of the budgetary assessment; and that both be paid at the same time.

Approved (page Tr 130)

(4) That the 1978 assessment be set at \$20 per capita for affiliate and associate members as it was for 1977.

Approved (page Tr 130)

Account	Current Budget 1976-77	Footnotes	Proposed Budget 1977-78
A- 1—Executive Salaries	\$128,895.00	(1)	\$ 145,327.00
A- 2—General Staff Salaries	262,708.50	(1)	291,797.65
A- 3—Gen. Exec. Office Expenses	39,000.00	(2)	43,000.00
A- 4—Executive Travel	4,700.00	(3)	6,200.00
A- 5—House Maintenance	36,800.00	(4)	42,600.00
A- 6—Treasurer	11,800.00	(5)	14,200.00
A- 7—Finance & Budget	75.00		75.00
A- 8—Secretary	1,700.00	(6)	500.00
A- 9—Salary Taxes	21,200.50	(1)	23,104.35
A-10—Insurance	25,750.00	(7)	30,200.00
A-11—House Reserve	12,800.00	(8)	20,000.00
A-12—MSNJ Pension Plan	5,200.00	(9)	7,200.00
A-13—MSNJ Building Loan	12,240.00		11,700.00
A-14—MSNJ Computerized Record Keeping	23,500.00		24,000.00
C- 2—Legislation	10,000.00	(10)	16,000.00
C- 3—Public Health	3,600.00		3,800.00
C- 4—Public Relations	52,700.00	(11)	117,700.00
C- 5—Medical Services	750.00	(12)	1,300.00
C- 6—Mental Health	1,700.00		1,800.00
D- 1—President & Pres. Officers	21,700.00	(13)	30,000.00
D- 2—AMA Delegates	22,000.00	(3)	31,200.00
D- 3—MSNJ Auxiliary	8,195.00	(14)	9,700.00
D- 4—Medical Education	40,800.00	(15)	30,900.00
D- 5—Conference Groups	500.00		500.00
D- 6—Membership Director	26,000.00	(16)	35,000.00
D- 7—Emergency Medical Care	10,500.00	(17)	11,200.00
D- 8—Credentials	1,200.00	(12)	1,400.00
D-11—Med. Def. & Insurance	900.00		1,000.00
D-12—Mem. Inq. & Complaint	1,000.00		1,000.00
E- 1—Board of Trustees	10,000.00	(12)	11,500.00
E- 2—Contingent	20,000.00	(12)	23,000.00
E- 3—Judicial Council	1,000.00		1,000.00
E- 4—Legal Expense & Reserve Fund	13,000.00		13,000.00
E- 5—CMDNJ—Foundation	10,000.00		10,000.00
E- 6—Medical Student Loan Fund	6,000.00		6,000.00
E- 7—Authorized Reimbursement for Representatives to Meetings	5,000.00	(12)	6,000.00
E- 8—Physicians' Relief Fund	6,000.00	(18)	— 0 —
Totals	<u>\$858,914.00</u>		<u>\$1,022,904.00</u>

(1) Increase due to increments granted to both executive and general personnel.

(2) Increased to cover higher luncheon cost, leasing of a Xerox/Cheshire 730 Addressing System, IBM Copier, and preventive maintenance agreements. This account covers also monthly interest payments on the purchase of telephone system, second of five years.

(3) Increased because the 1977 AMA Convention will be held in San Francisco and the 1977 AMA Clinical Meeting will be held in Chicago.

(4) Increased to cover higher utility and maintenance costs.

(5) Increased to cover higher Accounting and Auditing Service costs.

(6) Decreased because the Constitution Secretary will not be sent as a representative to AMA Convention and Clinical Meeting.

(7) Increased to cover higher expenses anticipated under the insurance program for the MSNJ Personnel.

(8) Increased to cover anticipated cost of interior remodeling of MSNJ Executive Offices to meet fire and safety standards.

(9) Increased to cover higher cost in Group Life Insurance as provided for MSNJ Pension participants.

(10) Increased to cover higher expenses associated with MSNJ providing soft dollar, administrative assistance to JEMPAC.

(11) Increased to cover higher expenses associated with the expanded Public Relations programs.

(12) Increased to cover higher specific expenses charged to this account.

(13) Increased to cover a \$100 per diem allowance provided for members of the Executive Committee and/or those officially representing MSNJ approved by the Executive Committee.

(14) Increased to cover higher expenses anticipated by the MSNJ Auxiliary formerly known as Woman's Auxiliary.

(15) This account provides for the Medical Education Committee, with the concurrence of the Board of Trustees,

to expend up to \$25,000 in the course of the administrative year (1977-78) to the Academy of Medicine of New Jersey for post-graduate educational programs and activities, on the basis of need reflected in the fiscal report to be submitted by the Academy to the Committee on Finance and Budget.

(16) Increased to cover higher anticipated publishing cost associated with the 1978-79 edition of the Membership Directory.

(17) Increased to cover higher expenses. Also provides the Inter-Agency Commission on Emergency Medical Care with an allocation for 1977-78 of \$10,000.

(18) No allocation is provided for 1977-78. Based on an audit by IRS, The Physicians' Relief Fund has been found to be in violation to the 501-(C)-(6) Non-Profit status MSNJ has held over the years.

**Filed (page Tr 130)**

**It was the recommendation of Reference Committee "B" that the annual reports of the Treasurer and the Committee on Finance and Budget be mailed to the delegates with the other annual reports prior to the Annual Meeting, when technically feasible.**

#### STATE SOCIETIES DUES FOR THE YEAR 1977\*

Below are the fifty-two State Societies in the order from the highest dues assessment down to the lowest:

1. Wisconsin	\$300.00	27. Maryland	\$155.00
2. Wyoming	300.00	28. New Hampshire	150.00
3. District of Columbia	295.00	29. New York	150.00
4. Idaho	274.00	30. Oklahoma	150.00
5. Nevada	260.00	31. Pennsylvania	150.00
6. Alaska	250.00	32. West Virginia	150.00
7. Arizona	250.00	33. Washington	147.00
8. Oregon	250.00	34. Michigan	145.00
9. Arkansas	225.00	35. Puerto Rico	140.00
10. Georgia	225.00	36. New Mexico	135.00
11. Kentucky	225.00	37. Illinois	131.00
12. Minnesota	225.00	38. Tennessee	130.00
13. South Carolina	220.00	39. Florida	125.00
14. Hawaii	215.00	40. Kansas	125.00
15. Iowa	200.00	41. Alabama	125.00
16. Louisiana	200.00	42. North Dakota	125.00
17. Maine	200.00	43. Mississippi	125.00
18. South Dakota	200.00	44. Ohio	125.00
19. Montana	200.00	45. Nebraska	120.00
20. Utah	195.00	<b>46. New Jersey</b>	<b>120.00</b>
21. Colorado	185.00	47. Massachusetts	110.00
22. Indiana	181.00	48. Virginia	105.00
23. Delaware	180.00	49. Connecticut	100.00
24. Texas	180.00	50. Vermont	100.00
25. Rhode Island	175.00	51. North Carolina	95.00**
26. California	165.00	52. Missouri	90.00

\*Average Dues — \$158.00  
Mean Dues — \$165.00

\*\*New members pay \$145.00  
first five years

# Medical Defense and Insurance

Paul J. Kreutz, M.D., Chairman, Elizabeth

(Reference Committee "C")

Since the last annual report, the Committee has approved, and E. & W. Blanksteen is preparing to implement, two significant improvements in the programs that they administer:

1. As soon as Insurance Department approval is received on the Disability Income Plan extension, additional past-age 70 coverage will become available to present policyholders whose plans currently terminate at age 70. When the extension of coverage is approved by the Insurance Commissioner, it automatically will be made available to those reaching age 70.

2. A revision of E. & W. Blanksteen's Major Expense plan was approved, to take effect March 1st, 1978, which will make available physicians' and surgeons' fee coverage (as an option to the Major Expense policy); nurse limits will be increased 65 percent, and the under-Medicare deductible will be reduced from \$750 to \$200! This new, revised program will be offered to all present participants on a guaranteed roll-over basis with each participant under the age of 65 having the choice of whether to take the physicians' and surgeons' fee option. Members over 65 will receive coverage identical to that which they now have, with the increased nurse limits.

## ACCIDENT AND HEALTH INSURANCE

The Society's Accident and Health Insurance programs are administered by the E. & W. Blanksteen Agency, Inc., who has just completed its 46th year of service to our members. This comprehensive disability income program now affords a monthly benefit up to \$4,600 during total disability due to injury or sickness. The program consists of two parts: The Basic-Extended Plan and the Long Term Plan. The plans differ primarily in the length of time benefits are payable. For an accident disability, the Basic Plan pays up to five years; the Basic-Extended Plan up to lifetime; and the Long Term Plan up to lifetime. For a sickness disability, the Basic plan pays up to two years; the Basic-Extended plan up to seven years; and the Long Term plan up to age 65 and beyond. Both the Basic-Extended Plan and the Long Term plan are underwritten by the Nationwide Mutual Insurance Company. Members may carry up to \$4,600 of which up to \$2,000 may be in the Basic Plan and up to \$3,600 a month in the Long Term plan. Up to three policies are

issuable to any member for maximum flexibility. The Company will rearrange policies and existing coverage to accommodate changing needs within the three-policy limit.

## BASIC-EXTENDED PLAN

The Basic Disability Plan provides as much as \$2,000 monthly benefit. Benefits are payable from the first day of accident total disability for as long as five years and the eighth day of sickness total disability for as long as two years. Waiting periods of 30 or 60 days are available to provide reduced premiums for those whose circumstances make desirable a plan where benefits could begin on a later date than first day accident and eighth day sickness. The plan also pays, at half the monthly rate, accident partial disability benefits for as long as six months. Also included in the plan are accidental death and dismemberment benefits. By adding the Extended plan, accident total disability benefits may be extended to lifetime and sickness benefits extended for an additional five years, for a total of seven years. There are 4,523 basic policies covering our members with some members having two basic policies. It is the Administrator's practice to combine those basic policies into one whenever members revise or increase their insurance programs so as to simplify their record-keeping.

## LONG TERM PROFESSIONAL INCOME PROTECTION PLAN

Members now may carry up to \$3,600 under this plan. Benefits are payable for lifetime for accident total disability and to age 65 and beyond for sickness total disability. One of the chief purposes of this plan is to provide both accident and sickness disability benefits to the age where other financial arrangements begin to fall into place: such as annuities, life insurance settlement options, and social security. The plan also affords six months of accident partial disability benefits at half the monthly benefit rate. Benefits may begin from the 31st, 61st, 91st or



181st day of disability, with appropriate reductions in premium. One thousand nine hundred twenty-two (1,922) members currently participate in this program which began in 1965.

It is possible for a member to have the various disability plans in almost any combination of monthly benefit and plan to fit personal requirements. The ideal goal for most doctors is to insure about two-thirds of monthly gross income. More monthly benefit than this is unnecessary inasmuch as all benefits are tax free for Federal Income Tax purposes. Members who apply for the Basic Plan within their new member periods are issued coverage, within certain limits, without regard to medical history.

All of our accident and health policies have the guaranteed Conversion Provision Rider. Briefly, this rider provides that if Nationwide were unilaterally to terminate any of its accident and health insurance programs for members of the Society, the Company is committed to issue a guaranteed renewable policy for the same benefits as are provided for in the doctor's original policy.

#### MAJOR EXPENSE PLAN

Our Major Expense Plan was improved (effective March 1, 1975) by the addition of the "quarter million" dollar rider extending coverage beyond the \$25,000 limit of the base policy to \$250,000 for members below Medicare age.

Until \$25,000 has been paid on any claim, the room and board rate is \$100 daily for intensive care and \$50 for all other accommodations. The private duty nursing benefit takes into account as covered expense \$24 for each eight-hour shift. (RN or LPN in the hospital; RN at home.) Also, certain services and supplies both in and out of hospital are covered. After a \$750 deductible for each benefit period, 80 percent of covered expenses is paid up to a maximum of \$25,000. There is *no* coordination-of-benefits provision for those below Medicare age! After the base policy has paid \$25,000 and the claim continues, the "quarter million" dollar rider takes over with expanded coverage (since primary hospital plans may be exhausted by this

time). Hospital room and board coverage is now full semi-private cost (up to double for intensive or coronary care units) and covered nursing charges are paid in full. The services and supplies covered by the base plan continue to be covered by the rider; 100 percent of covered expenses is reimbursed, and benefits are *not* reduced because of other non-government coverage.

This program now covers 2,441 members with many members including coverage for their wives and children. New members to the Society may obtain coverage under the Major Expense Plan without regard to medical history, provided they apply within their allotted two-month, new-member period. E. & W. Blanksteen Agency, Inc., administers this plan.

#### HOSPITAL-MONEY PLAN

Our Hospital-Money Policy, administered by E. & W. Blanksteen Agency, Inc., provides \$20, \$30, \$40, \$50, or \$60 a day for each day of hospital confinement up to a maximum of 365 days for any one confinement. It can cover member, spouse, and dependent children. New members are able to obtain the \$20 a day program non-selectively as part of their new-member privilege. Benefits under this plan are paid regardless of other insurance and are used to supplement the benefits provided by Blue Cross, Major Expense, and Major Medical plans. It is particularly useful to provide money for private-room coverage where adequate provision is not made by underlying plans. Two hundred ninety-two (292) members participate in this program.

#### OVERHEAD EXPENSE PROGRAM

Many of our members find that their overhead expenses have become quite high, with employees' salaries, rentals, and other fixed expenses pertaining to their practice. Our Professional Overhead Expense Program is underwritten by the National Casualty Company and administered by the E. & W. Blanksteen Agency, Inc. It provides up to \$2,500 monthly benefit beginning with the 31st day of total disability and lasting as long as two full years. Currently 349 members are covered under the plan. In accordance with IRS regulations, the premiums

under this program are considered business expense *and are tax deductible.*

**LIFE INSURANCE—NATIONWIDE LIFE  
INSURANCE COMPANY AND BANKERS  
LIFE COMPANY OF DES MOINES, IOWA**

The maximum coverage under our Life Plan is \$250,000 with the \$100,000 maximum coverage Bankers Life Plan available in addition to the \$150,000 program of the Nationwide Life Insurance Company that has been in effect for many years. Our original Nationwide Life Insurance Program includes not only the member but also his spouse and dependent children (between the ages of 15 and 21, up to age 26 if a college student), as well as employees. An important feature of this expansion is that each person will have his own five year renewable and convertible term policy, and it is not necessary for the member to take out insurance for himself in order to provide coverage for a member of his family or an employee. This added feature enables the life insurance program to serve many more needs of our members, especially those who wish to provide benefit programs for their employees. The administrators are E. & W. Blanksteen Agency, Inc.

The Nationwide life program provides each insured person with a five year renewable and convertible term policy with a guaranteed conversion on a non-medical basis to permanent life insurance at any time. The program now provides up to \$150,000 of coverage for members and up to \$50,000 of coverage for spouse, dependent children and employees. All coverage is issued in the form of convenient units of \$10,000 with waiver of premium and double indemnity for accidental death included without premium charge. Since inception of the program, there have been 322 death claims, resulting in a total pay-out of \$3,496,900.

As a result of the large volume of insurance and strong participation of our members in this program, we are able to have noncancellable term life insurance at a very low cost. At the present time, over 1,800 of our members participate in the program with approximately \$31,000,000 of insurance currently in force. This plan is also available to spouses, children

and employees, and 115 of them participate in this program.

The additional \$100,000 coverage through the Bankers Life Company is available to members whether or not they carry insurance under the original program. This will make possible large amounts of insurance without the necessity of another physical examination and give our members even greater flexibility in establishing their insurance program. The net cost and structure of the Bankers Life Program is quite similar to that of the Nationwide Life Insurance Company described above.

One hundred seventy-five (175) of our members have so far applied for and were issued \$7,112,500 of insurance protection under this new plan.

**SIX POINT, HIGH-LIMIT ACCIDENT  
INSURANCE PLAN**

Our Six Point, High-Limit Accident Insurance Plan with the Nationwide Mutual Insurance Company, administered by E. & W. Blanksteen Agency, Inc., provides up to \$200,000 for accidental death benefit with dismemberment benefit, loss of sight, exposure, disappearance, and even a total disability feature, at less than the usual cost of the accidental death benefit alone.

Special spouse coverage is available under this policy at very low cost. Seven hundred forty-five (745) of our members participate in this program.

**PROFESSIONAL CORPORATIONS**

E. & W. Blanksteen Agency, Inc., our administrator for the Basic-Extended, Long Term Professional Income Protection Plan, Major Expense Plan, Hospital-Money Plan, Six-Point High Limit Accident Insurance Plan, Overhead Expense Plan and Life Insurance Plan, has advised that all the programs are adaptable for use in professional corporations with necessary assignment forms available upon request.

**Recommendation**

That the E. & W. Blanksteen Agency, Inc., be continued as the Official Broker for MSNJ's

Accident and Health Insurance, Major Expense Insurance, Hospital-Money Plan, Life Insurance, Six Point High-Limit Accident Insurance, and Professional Overhead Expense Plan.

Approved (page Tr 133)

#### PROFESSIONAL LIABILITY

The events of this past year dealing with the professional liability program have been recounted in a multiplicity of communications to the membership and consequently need no duplication here.

At this writing 4800 physicians have chosen to purchase their professional liability insurance from the Medical Inter-Insurance Exchange of New Jersey. That company is soundly financed and well staffed. We are now working closely with the Exchange and the New Jersey State Medical Underwriters, Inc. to develop a formidable and effective claims' review and defense system.

Sound management concepts and some innovative techniques are being developed. Coupled with anticipated legislative reforms and a consistently increasing physician and public education effort, we are hopeful that the future of our professional liability program will reveal a leveling and a departure from the adverse trending of the past.

We currently are awaiting statistical data on rate developments for the next policy year. Because of the change in anniversary dates of the policies, it is impossible to present rate data for the February 1, 1978 issuance. We expect to work actively on that problem with both the Exchange and the Underwriters over the Spring and Summer and will report to the members of the House and the membership in the Fall.

A more detailed statistical accounting will be contained in the report of the New Jersey State Medical Underwriters, Inc., which is also before this House of Delegates.

#### STATEWIDE BLUE CROSS/ BLUE SHIELD PROGRAM

The Statewide Blue Cross/Blue Shield program

has been in effect since 1972 and there are now almost 5,000 doctors from 16 counties participating in the program. The coverage is also available to a doctor's full-time employees, if the doctor wishes to use the program as a fringe benefit for his employees.

The program provides 120-day comprehensive Blue Cross coverage and a choice of the 500 Series, 750 Series, or Prevailing Fee (UCR) Blue Shield schedules. In addition to these standard benefits, the program includes the following additional benefits:

1. Unmarried children are covered until the end of the year in which they turn age 23, instead of age 19.
2. Coverage under the program may be continued by the surviving spouse and dependent children of a deceased member.
3. The full semi-private rate is paid in non-member hospitals outside New Jersey, instead of the standard \$30 per day payment.
4. There is 120 days' coverage for mental conditions, tuberculosis, alcoholism, polio, and contagious diseases, instead of the standard 20 days.
5. The program provides 120 days semi-private care *per admission*, instead of 120 days per benefit year.

The program is administered by Donald F. Smith & Associates. Coverage is available to members of the Society without regard to their previous medical history. New members may join within two months of becoming a member and present members may join during one of the open enrollment periods in June or December. Coverage will become effective on the following July 1 and January 1, respectively.

This program is still the most comprehensive method of providing basic health care insurance for our members in the State today.

#### NEW BLUE CROSS/BLUE SHIELD GROUP MAJOR MEDICAL PROGRAM

The new group major medical program for doctors became available on January 1, 1977. More than 1,400 doctors and their families became covered on that date.

This new program is designed and administered by Donald F. Smith & Associates. It is



truly a group insurance program and offers many of the advantages which were formerly available only to those covered under employer-sponsored plans. Some highlights of the plan are:

1. The maximum payment under the Plan is \$50,000 per person per calendar year, except for out-of-hospital treatment of mental conditions which is limited to \$1,000 per calendar year. There are unlimited lifetime benefits.
2. Physicians' and surgeons' charges are covered expenses.
3. Benefits are payable when covered expenses for all illnesses and accidents exceed the benefits under the Medical Society's statewide Blue Cross/Blue Shield program, plus a cash deductible of \$100. It is not necessary to satisfy a new cash deductible for each separate accident or illness. And, there is a maximum of two deductibles per family per calendar year.
4. The premium rates are low and do not increase with age.
5. The full semi-private hospital room and board rate is a

covered expense, and there is an additional allowance for a private room.

New members of the Society will be able to join within 60 days of becoming a member. The program will be available only to present members during the semi-annual open enrollment periods in June and December. Coverage will become effective on the following July 1, and January 1, respectively.

### **Recommendation**

That Donald F. Smith and Associates be continued as MSNJ's Official Broker for its Blue Cross-Blue Shield Program and its Blue Cross-Blue Shield Group Major Medical Program.

**Approved (page Tr 133)**

**Filed with commendation to the Chairman (page Tr 133)**

## **Medical Education**

**Arthur Bernstein, M.D., Chairman, Maplewood**  
(Reference Committee "D")

The Committee on Medical Education now has been able to inspect and accredit all of the hospitals in the State that have requested this service. Furthermore, we have started to resurvey those hospitals who had one or two year accreditations and have reevaluated their status. As a result of this effort there are very few areas in the State where accredited programs are not being held on a weekly or monthly basis, and in many hospitals there are two, three, or four accredited programs per week.

June 1, 1976, saw us reach our deadline for the membership to achieve 150 hours of continuing medical education credit over a three-year period in order to retain membership in The Medical Society of New Jersey. Presently, because of marked delays in receiving material from the AMA due to computer failure the auditing procedure has not been completed.

As of February 1, 1977, 2,897 of our 9,416 members are not accounted for as yet. We are now in the midst of confirming by direct mail communication the status of these physicians. Unfortunately, computer breakdown has caused us a very marked delay in implementing this program and your Committee must apologize to the entire membership for this failure. We sincerely hope that by the time of the Annual Meeting we shall have a final firm figure which will be authoritative.

In order to avoid such debacles in the future, we will be utilizing our own computer program which will make it much easier for us to record each physician's attendance as we go along. Then at the end of any given three-year period we will have all of the information we need at our fingertips, without delays and communication failures.

In addition, your Committee on Medical Education met with a representative of the Academy of Family Physicians to try to work out a program whereby accreditation of a program by the Academy of Medicine and/or an accredited hospital program also would receive credit from the New Jersey Academy of Family Physicians. We hope that it will come to fruition shortly, thereby avoiding duplication of effort.

Your Committee was requested by Resolution #23 of last year's House of Delegates to set up a monitoring system of fees charged for programs in the State of New Jersey. This was done and we will investigate any of those that seem to be out of line.

The Committee on Medical Education is keeping a close watch on the new accreditation committee that is being set up by the AMA called the Liaison Committee on Continuing Medical Education, which is a subcommittee of the Coordinating Council on Medical Education. This will consist of representatives from the AMA, the Association of American Medical Colleges, American Board of Medical Specialties, American Hospital Association, Council of Medical Specialty Societies, the Federal Gov-

ernment, and the public. The various state medical societies that will be affected by this new committee are attempting to form a united group in order to secure representation of the state medical societies on this liaison committee so that our voices will be heard. This is still in the talking stage.

Your Committee has maintained strict rules and regulations in its accreditation of hospitals and their programs. There has been a visible improvement in attendance, attitude, behavior, and patient care in the accredited hospitals. This will be monitored carefully and ultimately a report on the actual benefits derived will be submitted.

The Chairman wishes to thank the members of the Committee for their diligence in attendance and for the long hours spent trying to unravel the lists of people who truly have received their credits and yet are not on the AMA lists. They deserve a "well done" from the entire membership for their diligence and extra work in order to try to bring this task to a fruitful conclusion.

**Filed, with commendation to the chairman and members of the Committee (page Tr 134)**

## Medical Student Loan Fund

**William Greifinger, M.D., Chairman, Newark**

(Reference Committee "B")

In its twenty years of operation the Medical Student Loan Fund has granted loans totaling \$492,144.35 including \$444.35 as insurance payments, bringing the net loans granted to \$491,700.00.

To date the Fund has issued 406 loans to 251 New Jersey medical students. One hundred and sixty-two loans have been repaid in full. Seventeen borrowers are presently making quarterly repayments on an annual basis.

Forty-seven requests for financial assistance by New Jersey medical students were received during the 1976-77 administrative year, and thirty-three loans in the amount of \$1,500 each were granted for a total of \$49,500. It is expected that this trend will continue for some time.

It is estimated that the Fund will have \$43,000 available for loans for the 1977-78 school year to accommodate twenty-eight students at

\$1,500 each. Of this amount \$19,500 is committed to thirteen re-applicants, \$23,500 to sixteen new student applications. At this time we have ten additional eligible applicants that the Medical Student Loan Fund cannot consider for financial aid for the fiscal year beginning June 1, 1977.

This report does not reflect all the anticipated applications from other qualified medical students and your Committee is mindful also of the ever-increasing tuition rates. However, at this time, it does not feel it can afford to increase the \$1,500 yearly loan limit.

Your Committee has had continued encouraging results from its solicitation of past loan recipients now serving an internship or residency to initiate early repayment of their loans on an interest-free basis. This year fourteen loans have been paid in full, a total of \$13,150. The financial activities of the Fund during the year are included in the report of the Treasurer.

Your Committee warmly commends Mr. Lambert and Mr. Squireck for their consistently efficient administrative assistance.

#### PRESENT LOCATION OF RECIPIENTS OF LOANS

The 112 graduates are located as follows:

Interns—1 in New Jersey and 10 out-of-state	11
Residents—11 in New Jersey and 41 out-of-state	52
Armed Service—4 Army of the United States, 3 United States Navy, and 1 United States Air Force	8
Private Practice—	
2 Arizona	3 California
1 Connecticut	2 Florida
1 Massachusetts	15 New Jersey
4 New York	1 Ohio
5 Pennsylvania	2 South Carolina
1 Texas	3 Virginia
1 Washington, D.C.	41
Students presently in medical school—19 seniors, 13 juniors, and 2 fifth channel	34
Current student loans outstanding	146
Medical students paid in full (162 loans)	105
Total New Jersey medical students (as listed earlier)	251

#### CONTRIBUTIONS

The Committee is grateful to the many contributors to the Fund, and takes this occasion to acknowledge their support. A list of Contributors since the last report follows:

#### (1) General Fund:

The Medical Society of New Jersey, Board of Trustees; MSNJ's Auxiliary Executive Board; MSNJ's Auxiliary Fellowettes; County Medical Societies: Burlington, Cape May, Mercer, Passaic, and Warren; County Auxiliaries: Atlantic, Bergen, Burlington, Camden, Cape May, Essex, Gloucester, Hudson, Mercer, Middlesex, Passaic, Union, and Warren; American College of Obstetricians and Gynecologists, Dr. and Mrs. Alexander Bertland, Dr. and Mrs. James Brennan, "The Becks," Goldie Beck, Dr. and Mrs. Robert Cornwell, Mr. Henry F. Decker, Mrs. Don A. Epler, Dr. and Mrs. David Eckstein, Dr. and Mrs. Philip Fiscella, Mr. and Mrs. K. M. Guthrie, Dr. and Mrs. Elmer L. Grimes, Dr. and Mrs. Clifford Gorden and Family, Mrs. J. Goldberg, Dr. and Mrs. Arthur F. Gross, Dr. and Mrs. John A. Ianacone, Dr. and Mrs. Joseph R. Jehl, Dr. and Mrs. John F. Kustrup, Dr. and Mrs. Samuel J. Lloyd, Mrs. Helen B. Lifland, Dr. and Mrs. Nicholas E. Marchione, Mrs. Carl Maxwell, Dr. and Mrs. Edward McCartin, Mrs. Marcella Mulligan, Mr. and Mrs. G. Musaria, N.J. Optometric Association, Dr. and Mrs. Paul H. Pettit, Dr. and Mrs. Joseph Scarano, Dr. and Mrs. J. Scillieri, Dr. and Mrs. A. Semet and Family, Charlotte Semet, Harriet Schwartz, Mrs. Mildred Tarchiani, Dr. and Mrs. Irving Weiss, Edward A. Wolfson Family, Yardley-Makefield Lions Club.

#### (2) In Memory Of:

Abraham H. Apter, M.D., Sotiris A. Athans, M.D., John J. Bedrick, M.D., Ugo Boccaletti, M.D., Joseph J. Bono, M.D., Luther S. Bradley, M.D., Mrs. Alton E. Bythewood, Alfred J. D'Agostini, M.D., Henry B. Decker, M.D., William B. Farran, Paul J. Finegan, M.D., Mrs. Barbara Fitts, Mrs. John Fitzgerald, Frank S. Forte, M.D., Frank A. Frankovic, Robert Y. Garrett, Jr., Augustus G. Goetz, Albert S. Harden, M.D., Vincent Halbert, Dr. Emmett Hay, Gerhard R. Hirschfield, M.D., Alexander A. Introcaso, M.D., Eleanor Ivers, Walter L. Jordan, M.D., Ralph Jungali, Dorothy Klughaupt, M.D., Ruth S. Knott, Frank Kren, M.D., Steven Girard Lax, Albert T. Lemay, M.D., David B. Levine, M.D., Mrs. Caroline Litz, Dr. J. Francis Mahoney, Louis Markowitz, M.D., Lawrence P. Marron, Mrs. Katherine McGuigan, John J. McGuire, M.D., Walter Miller, William Missonellie, M.D., Harry A. Moscoe, M.D., Dr. Rade R. Musulin, James E. Neri, Dr. Irving Okin, Mrs. Felomena Oltremare, John H. Reiners, Jr., Eugene V. Robertson, M.D., Wilbert Sachs, M.D., Michael Silver, M.D., Irving Solomon, Jack Wagenbrenner, Marc J. Wallace, M.D., Jacob Warren, M.D., John L. Wikoff, M.D., Walter M. Winters, M.D., David Wolfson.

#### (3) In Honor Of:

The Medical Society of New Jersey, Board of Trustees; Jerome Bellet, M.D., Thomas Cavaliere, Dr. Harvey Cohen, Dr. Jane Colfay, Mrs. Frank Doggett, Jr., Dr. E. Eisenstein, Matthew C. Kartch, M.D., Dr. Joseph Mayner, Herbert Rosenthal, M.D., S. Sanders, M.D., Bernard Simon, M.D., Mr. and Mrs. Louis Stark, Robert Steinfeld, M.D., Mrs. Lucius Tarchiani, Abraham Topchik, M.D., Irving Weiss, M.D., MSNJ's Auxiliary Executive Board, Past Presidents.



# DISTRIBUTION OF LOANS

<i>County of Residence</i>	<i>Medical School</i>	<i>Students</i>	<i>1975-76</i>	<i>1976-77 March 31, 1977</i>
Atlantic	Hahnemann	3	\$ 3,000	
	N.J. Medical	1	1,000	
	Pittsburgh	1	2,000	
	Temple	1	1,000	
	Tufts	1	4,000	
Bergen	Albert Einstein	1	1,500	\$ 1,500
	Boston	1	1,000	
	Creighton	1	1,000	
	Hahnemann	3	5,000	
	Jefferson	3	6,000	1,500
	Loyola-Stritch	1	3,000	
	Med. Coll. Pa.	1	3,000	
	N.J. Medical	10	14,000	1,500
	N.Y. Medical	3	5,500	
	Rutgers	2	1,500	1,500
	St. Louis	2	3,000	
	Tufts	1	3,000	
	U. of Pa.	1	1,500	1,500
Burlington	Duke	1	4,000	
	Georgetown	1	1,500	1,500
	Hahnemann	2	2,500	1,500
	Jefferson	3	9,500	
	Med. Coll. Pa.	1	1,500	
Camden	Albert Einstein	1		1,500
	Hahnemann	5	8,000	1,500
	Jefferson	3	6,500	
	Michigan	1	2,000	
	N.J. Medical	2	2,700	
	Temple	5	7,500	
	Tufts	1	1,500	1,500
Cumberland	Jefferson	1	2,000	
Essex	Albany	1	4,000	
	Bern	1	2,000	
	Creighton	2	3,000	3,000
	Duke	1	2,000	
	Emory	1		1,500
	Georgetown	3	4,000	
	Hahnemann	4	9,500	
	Howard	1	300	
	Jefferson	1	3,000	
	N.J. Medical	24	48,900	3,000
	N.Y. Medical	2	2,000	
	Stanford	1	3,000	
	St. Louis	1	500	
	Temple	1	1,000	
	Tufts	2	1,500	3,000
	Wisconsin	1		1,500
Gloucester	Hahnemann	1	1,000	
	Temple	1	2,000	
	Virginia U.	1	1,000	
Hudson	Boston	1	3,000	
	CMDNJ 5th Channel	1	1,500	
	Georgetown	1	1,000	
	George Washington	1	3,000	
	Hahnemann	1	1,500	
	Harvard	1	1,000	

	Howard	1	400	
	Med. Coll. Pa.	1	1,500	
	N.J. Medical	22	37,650	
	N.Y. Medical	1	1,000	
	Pittsburgh	1	3,000	
	St. Louis	1	2,000	
Hunterdon	Hahnemann	1	1,500	1,500
	Rutgers	1	1,500	
Mercer	CMDNJ 5th Channel	2		3,000
	Georgetown	2	4,500	
	Hahnemann	4	6,000	1,500
	Howard	1	1,000	
	Johns Hopkins	1	1,000	
	Louisville U.	1	4,500	
	Meharry	1	250	
	Mississippi	1	3,000	
	N.J. Medical	5	9,500	
	N.Y. Medical	1	1,500	
	Pennsylvania U.	1	1,000	
	Rutgers	1		1,500
	St. Louis	1	700	
	Tufts	1	3,000	
	Wisconsin	1	1,500	
Middlesex	Georgetown	2	1,500	1,500
	Hahnemann	1	4,000	
	Loyola-Stitch	1	1,500	
	N.J. Medical	2	3,000	
	N.Y. Medical	2	4,500	
	Rutgers	1	3,000	
	Wisconsin	1	1,500	
Monmouth	Albert Einstein	1	1,500	
	Bowman Gray	1	1,500	
	Columbia	1	2,000	
	Duke	1	3,000	
	Georgetown	1	1,000	
	Hahnemann	1		1,500
	Jefferson	2	6,000	
	Loyola-Stitch	1	4,500	
	Marquette	2	3,500	
	Med. Coll. Pa.	1	1,500	
	N.J. Medical	3	10,000	
	N.Y. Medical	1	4,000	
	Temple	1	2,000	
	Up-State N.Y.	1	1,000	
Morris	Albany	1		1,500
	Case Western	1	1,000	
	Dartmouth	1	1,000	
	Duke	1	1,000	
	George Washington	1		1,500
	Loyola-Stitch	1	1,500	
	Michigan	1	1,500	
	N.J. Medical	3	7,500	
	Tufts	1		1,500
Ocean	Med. Coll. Pa.	1	3,000	
	Rutgers	1	3,000	
	SUNY-Downstate	1	1,500	
	Tufts	1	3,000	
Passaic	Jefferson	1	3,000	
	N.Y. Medical	2	1,000	1,500
	Wisconsin	2	3,000	

Salem	Duke	1	1,500	
	Jefferson	1	3,000	
Somerset	Georgetown	1	1,000	
	N.Y. Medical	1	2,000	
	Temple	1	3,000	
	Western Reserve	1	1,000	
Union	CMDNJ 5th Channel	1	1,500	
	Florida	1	1,000	
	Georgetown	2	3,000	1,500
	Hahnemann	3	4,000	1,500
	Jefferson	3	4,500	3,000
	N.J. Medical	12	20,800	
	N.Y. University	2	4,500	
	Wisconsin	1	3,000	
18 Counties	40 Medical Schools	251	\$442,200	\$ 49,500
Total loans granted 3/31/77				\$491,700

### Recommendations

(a) That the House of Delegates concur in the recommendation of the Finance and Budget Committee—approving a budget appropriation of six thousand dollars in lieu of a special per capita assessment for 1977-78 in support of the Medical Student Loan Fund.

**Approved (page Tr 130)**

(b) That the MSNJ membership be urged to

continue their active support by sending contributions to the Fund.

**Approved (page Tr 130)**

(c) That The Medical Society of New Jersey Auxiliary be requested to make the Fund its number one project next year.

**Approved (page Tr 130)**

**Filed (page Tr 130)**

## Publication

**Daniel B. Roth, M.D., Chairman, Teaneck**  
(Reference Committee "B")

The communication needs of our members and our Society are being met by an increasingly larger *Journal*. The total number of pages included in the past year represents the addition of an entire issue when compared with the page count of only a few years ago.

*The Journal* continues to receive large numbers of manuscripts of variable quality—some excellently written, but some less eloquent. The Manuscript Review Board has done a superb

job of reviewing the material so that our coveted pages are getting the best use. Book reviewers are to be commended for their contribution to *The Journal*. The participation in our publication of these two groups means that it is truly a product in which many of the Society's members are involved.

The most troublesome task facing *The Journal* continues to be the management of finances. Two factors should enable the increasing adver-



tising revenues to match increasing production costs in the forthcoming fiscal year—lighter weight inside paper stock will minimize spiraling paper mill costs and the use of economical web presses will lower presswork charges.

We would like to call attention to the recognition given to *The Journal* of The Medical Society of New Jersey, in preliminary commentary by the faculty of the recent Sandoz Medical Journalism Workshop, as one of the three best

state society journals with circulations over 3,000. Final judgment in the Sandoz Awards will be announced later this year.

Special commendation goes to Dr. Arthur Krosnick for the increasingly excellent quality of our publication. Acknowledgment is made also to the assistant editor, the advertising manager, and their associates.

**Filed (page Tr 131)**

## Revision of Constitution and Bylaws

**Hillel M. Ben-Asher, M.D., Chairman, Morristown**  
(Reference Committee on Constitution and Bylaws)

### **Proposed Constitution of the Medical Society of New Jersey**

#### **Article I — Title**

The name of this organization is the "Medical Society of New Jersey."

#### **Article II — Purposes**

The purposes of this Society are to promote the betterment of the public health and the science and art of medicine, to enlighten public opinion in regard to the problems of medicine, and to safeguard the rights of the practitioners of medicine.

#### **Article III — Component Societies**

County medical societies that hold charters from this Society shall be known and referred to as component societies. There shall be no more than one component society in any county of this State.

#### **Article IV — Members**

This Society is composed of individual members of component societies who are entitled to full privileges and others as provided in the Bylaws.

#### **Article V — House of Delegates**

The House of Delegates shall be the legislative and policy-making body of this Society and shall consist of Fellows, Officers, and Delegates as prescribed in the Bylaws.

#### **Article VI — General Officers**

The general officers of this Society shall be the elected officers and elected trustees as defined in the Bylaws. Their terms of office and qualifications shall be provided in the Bylaws.

#### **Article VII — Trustees**

The Board of Trustees is composed of those elected officers so designated in the Bylaws and the elected trustees, and shall constitute the executive body of the Society at such times as the House of Delegates is not in session. Its duties are those prescribed by law governing trustees of corporations and as may be prescribed in the Bylaws.

#### **Article VIII — Sections**

The House of Delegates or the Board of Trustees may provide for the division of the scientific work of this Society into sections whenever the necessity therefor arises.

## **Article IX — Meetings**

The House of Delegates and the Scientific Sections shall meet at least annually and at such other times as are deemed necessary by the House or the Board of Trustees as provided in the Bylaws.

## **Article X — Funds, Dues, and Assessments**

Funds shall be raised by dues and assessments on the membership as approved by the House of Delegates as provided in the Bylaws.

## **Article XI — Councils and Committees**

Councils and Committees shall be established by the House of Delegates or the Board of Trustees as provided in the Bylaws.

## **Article XII — Amendments to the Constitution**

This Constitution may be amended in the following manner:

1. Submission in writing of an amendment proposed by the Board of Trustees, by the Judicial Council, or by a component society to the Secretary of this Society not later than December 31 of the year prior to the Annual Meeting.

2. Transmission by the Secretary of the proposed amendment within ten (10) days to the Standing Committee on Revision of Constitution and Bylaws and to each component society.

3. Publication of the proposed amendment in *The Journal* at least sixty (60) days before said meeting.

4. Submission of the report of the Standing Committee on Revision of Constitution and Bylaws concerning the proposed amendment at the first session of the House of Delegates and referral to the appropriate reference committee for hearing and study.

5. Report of the reference committee to the final session of the House of Delegates for appropriate action.

6. Acceptance by a two-thirds (2/3) vote of the House of Delegates present and voting at that final session.

**Adopted (page Tr 127)**

## **Bylaws**

### **Chapter I — Membership**

#### **Section 1 — Composition**

(a) This Society shall be composed of Fellows, Officers, Delegates, members, and associate members of component societies in good standing, and emeritus members. Honorary members may be elected, but they shall not be members of the corporate body. Affiliate membership may be granted but recipients may neither vote nor hold office.

#### **(b) — Fellows**

The Fellows are the Past-Presidents of this Society.

Any member of this Society, not already a Fellow, who is elected President of the American Medical Association, shall, at the completion of his term, become a Fellow of this Society.

(Note: The "immediate past-president" is that living past-president between whom and the president no succeeding living past-president intervenes.)

#### **(c) — Officers**

The Officers shall be a President, a President-Elect, a First Vice-President, a Second Vice-President, a Secretary, a Treasurer, the elected members of the Board of Trustees, and the Judicial Councilors.

#### **(d) — Members of Component Societies**

All members of component societies in good standing are hereby constituted members of this Society and are entitled to full privileges.

Associate members of component societies in good standing are hereby constituted associate members of this Society, but they may not vote or hold office.

(e) — *Emeritus Members*

Emeritus members shall be physicians who have been members in good standing of a component society and who by reason of age or infirmity have retired from the active practice of medicine; or members of this Society who have been disabled by reason of military service. Nomination shall be submitted by the component societies and emeritus membership shall be conferred by a majority vote of the House of Delegates. Emeritus members shall have all the privileges of membership except the right to vote and hold office, and their respective component societies shall not be assessed for such members provided they are carried as emeritus members in said component societies. Emeritus members shall not be included in the membership of a component society when computing the number of delegates to which such society is entitled. Active practice shall be determined by policy decision of the Board of Trustees or the House of Delegates.

(f) — *Honorary Members*

Any persons other than members of the Medical Society of New Jersey may be nominated by the Board of Trustees for election as Honorary Members. Nominees shall be elected by a two-thirds (2/3) vote of the House of Delegates during any session. Honorary members shall not be members of the corporate body and at no time may the number of living honorary members exceed twenty-five (25).

(g) — *Affiliate Members*

Affiliate members shall be physicians who have been active members for at least five consecutive years but who no longer practice in New Jersey. Applications for affiliate membership shall be directed, through the component medical society, to the Standing Committee on Medical Defense and Insurance of the Medical Society of New Jersey for consideration and action. Affiliate members shall be eligible to continue all insurance coverages offered by the Society. The dues for affiliate members shall be established by the House of Delegates on recommendation of the Committee on Finance and Budget.

**Section 2 — List of Members**

(a) The term member or membership unless otherwise qualified shall refer to those members having full privileges, including the right to vote and hold office.

(b) Five (5) days before the first of March the treasurer of each component society shall forward to the Treasurer of this Society a complete list, with names and addresses, of all paid up and exempt members in good standing in this Society, at the same time remitting the assessment covering such membership.

Not later than the first day of March in each year, the secretary of each component society shall send to the Secretary of this Society a current list of associate, emeritus, and honorary members; members elected, deceased, and those who have resigned or moved from the county since the last report was submitted. Where members have transferred or have been received on transfer, the name of the county or state society to or from which they have transferred must be given.

Immediately after December 31 of each year, the Secretary of this Society shall notify each component society of the number of delegates to which it is entitled during the next succeeding year in the House of Delegates, based on the number of active members recorded in the office of the Secretary on that date. Associate membership shall not be included in such computation.

Not later than the first day of April in each year, the secretary of each component society shall send to the Secretary of this Society a complete list of the delegates and alternate delegates to this Society, together with the names of the delegate and alternate delegate to the Nominating Committee.

(c) — *Ineligibility*

No person who is under sentence of suspension or expulsion from any component society, or whose name has been dropped from its roster, shall be entitled to any of the rights or privileges of this Society until relieved of such disability.



(d) — *Rules of Conduct*

The "Principles of Medical Ethics" adopted by the American Medical Association shall govern the conduct of members in all categories of the Medical Society of New Jersey in their relations to each other and to the public.

**Chapter II — Meetings**  
**Section 1 — Delegates**

Delegates shall be chosen by and from the component societies, and shall be members of this Society and of the House of Delegates for the period of time for which they are elected, subject to continuance of good standing in their respective component society, and further subject to their respective component society's continuing in good standing in this Society.

(a) — *Apportionment and Election*

Unless otherwise stipulated by the House of Delegates, each component society shall be entitled to such delegate apportionment as equitably and proportionately determined by the Secretary of the Medical Society of New Jersey in the interest of maintaining the total membership of the House so that it does not exceed four hundred (400) members, to be elected at any meeting prior to March 31 by a majority ballot of the members present. The term of office of each delegate shall be for three (3) administrative years and shall begin on April first next following his election. Each component society shall be entitled to at least three (3) delegates.

(b) — *Reapportionment*

In the event of geographic subdivision of any of the existing counties of New Jersey, and the creation of an additional component society, the delegates from the old and the new component societies shall be apportioned on the basis above provided.

(c) — *Delinquency*

In the event that a component society becomes delinquent to this Society, its entire delegation shall lose its status for the period of such delinquency.

(d) — *Vacancy*

A vacancy shall exist in the delegation of any component society whenever one (1) of its delegates ceases to be in good standing, or neglects to attend a majority of the sessions of the House of Delegates at two (2) consecutive meetings (annual or special). When such a vacancy occurs, the component society shall fill the unexpired term.

(e) — *Alternates*

Each component society shall elect, at any meeting prior to March 31 of the fiscal year, alternate delegates in number equal to the number of regular delegates. A regular delegate, if unable to attend any meeting of the House of Delegates, shall so inform the secretary of his component society who shall arrange the assignment of the delegate's credentials to an alternate. An alternate, when serving, shall have all the rights and privileges of a regular delegate.

A regular delegate, if unable to attend a session of any meeting of the House of Delegates, may inform the secretary of his component society who shall arrange the assignment of the delegate's credentials to an alternate. An alternate, when registered and seated in the House of Delegates shall retain his seat during the remainder of the meeting.

**Section 2 — House of Delegates — Meetings**

(a) — *Composition*

The House of Delegates shall be the legislative body of this Society, and shall consist of the Fellows, Officers, and Delegates.

(b) — *Speaker and Vice-Speaker*

The President shall have the power to appoint a Speaker of the House of Delegates at each annual meeting. The Speaker shall be a member of this Society, and his sole duty shall be to preside at the sessions of the House of Delegates. He shall not have the power to appoint committees.

The President shall also have the power to

appoint a Vice-Speaker of the House of Delegates at each annual meeting. The Vice-Speaker shall be a member of this Society, and his duty shall be to assist the Speaker in presiding at the sessions of the House of Delegates. He shall not have the power to appoint committees.

(c) The House of Delegates shall meet on the first day of the annual meeting of this Society, but may meet in advance of or after adjournment of the annual meeting. Sessions may be adjourned from time to time, as may be necessary, but shall be so arranged as not to conflict with the general sessions and section meetings. Unless otherwise ordered by the House of Delegates, all its sessions shall be in closed session. Closed session shall include Officers, delegates, registered members, and guests invited by the Chair.

(d) The annual meeting of the House of Delegates shall consist ordinarily of three (3) sessions. Except as otherwise provided, the principal business of these sessions shall be: First Session: presentation of annual reports, introduction of resolutions, introduction of new business, and assignment of same to reference committees; Second Session: report of Nominating Committee and election; Third Session: presentation of and action upon reports of reference committees, unfinished business, and inauguration of newly elected Officers.

(e) Consent of two-thirds (2/3) of the delegates present and voting shall be required for the introduction of new business at the last session of the House of Delegates during the annual meeting, except when presented by the Board of Trustees or the Committee on Finance and Budget. All new business so presented shall require a three-fourths (3/4) affirmative vote of the delegates present and voting for adoption of new business so presented.

#### (f) — *Credentials*

Each delegate shall present to the Reference Committee on Credentials a certificate bearing the Seal of this Society and the signature of its Secretary. A delegate will not be permitted to register or sit as a member of the House of

Delegates: (1) without such certificate, (2) if his assessment has not been paid, or (3) if his component society has not paid its annual per capita assessment.

#### (g) — *Quorum*

A quorum shall consist of at least ten per cent (10%) of the membership of the House of Delegates representing at least ten per cent (10%) of the delegation of each of seven (7) component societies.

#### (h) — *Voice, Vote, and Discussion*

(1) Only members of the House of Delegates shall have the right of vote. The privilege of voice may be extended by the House at its discretion, to other members and guests.

(2) The presiding officer, with the consent of the House of Delegates, shall be empowered to limit discussion.

#### (i) — *Authority*

The House of Delegates shall have the power to:

Prescribe the duties of its Officers and its members, fix their compensation, if any;

Assess from time to time an annuity upon the component societies in the ratio of their membership respectively;

Adopt such rules and regulations for the due management of this Society and the several component societies as may be deemed necessary;

Issue charters to county societies applying for affiliation with this Society;

Revoke the charter of any component society whose actions are in conflict with the letter of spirit of the Constitution and Bylaws, upon the recommendation of the Judicial Council.

### **Chapter III — Board of Trustees**

(a) The Board of Trustees shall be the executive body, and shall be composed of the Im-

mediate Past-President, President, President-Elect, two (2) Vice-Presidents, Secretary, and Treasurer (by virtue of their offices), and elected Trustees—at least two (2) from each judicial district for a membership up to one thousand (1,000); each judicial district shall be entitled to one (1) additional Trustee for each additional one thousand (1,000) members, or major fraction thereof, computed as of December 31.

(b) — *Organization*

At the first meeting of the Board of Trustees following each annual meeting of the House of Delegates, the President shall appoint with the advice and consent of the Board of Trustees, a chairman of the Board. The chairman shall name the membership of all committees of the Board of Trustees. Meetings shall be called by the chairman, but any four (4) Trustees may—in writing and for stated reason—require the chairman to call a meeting. Notices of meetings shall be mailed at least seven (7) days in advance of the meeting date. Nine (9) Trustees shall constitute a quorum. The Secretary of the Society shall serve as Secretary of the Board.

(c) — *Executive Committee*

The President, President-Elect, First and Second Vice-Presidents, Immediate Past-President, and the Chairman of the Board of Trustees shall compose the Executive Committee. It shall act on emergency measures when time does not permit a meeting of the Board of Trustees. Any action thus taken shall be subject to formal action of the Board of Trustees at its next meeting.

(d) — *Powers*

The Board of Trustees shall exercise general supervision over the affairs of this Society, shall have authority to act between annual meetings, and shall perform the following functions:

Make recommendations to the House of Delegates;

Assign business to and advise in the deliberations of committees;

Supervise the work of the Committee on Publication and appoint an editor and such other assistants as the publication of *The Journal* may require;

Make suitable provision for the efficient conduct of the business of this Society;

Engage counsel as necessary and negotiate fees for services to be rendered;

Determine all salaries;

Pass upon all recommendations for expenditures in excess of budgetary appropriations;

Bond the Treasurer, the Chairman of the Committee on Finance and Budget, and other necessary personnel;

Fill vacancies in all offices and elected committees unless otherwise provided in the Constitution and Bylaws.

(e) — *Property*

The Board of Trustees shall have sole authority to lease, sell, or otherwise convey or dispose of any or all property of this Society, both personal and real.

(f) — *Committee on Finance and Budget*

Three (3) Trustees shall serve on the Committee on Finance and Budget.

(g) — *Annual Report*

The Board of Trustees shall render annually to the House of Delegates a summary of its activities.

## Chapter IV — Judicial Council

(a) The Judicial Councilors collectively shall comprise the Judicial Council which shall be the judicial body of this Society. The House of Delegates shall organize five (5) councilor districts within the State. It shall elect one (1) Judicial Councilor from among the membership of each of the five (5) districts.



(b) — *Councilors*

The Councilors collectively, shall be known as the Judicial Council, and shall constitute the supreme judicial body of this Society. The Councilors shall elect their own chairman.

(c) — *Meetings*

The Judicial Council shall meet as soon after the annual meeting of the House of Delegates as is convenient for the purpose of reorganization. Thereafter, the Judicial Council shall meet as often as may be necessary to transact its business at the call of the chairman or at the request of any three (3) councilors. Three (3) members shall constitute a quorum.

(d) — *Duties of the Judicial Council*

The duties of the Judicial Council shall be as follows:

1. To sit as an appellate tribunal and to hear and determine any and all appeals properly brought before it from any county judicial committee.
2. To interpret and rule upon all questions of an ethical nature that shall confront the House of Delegates or any other board or committee of this Society.

[3. To adjudicate all disputes or controversies arising within the Medical Society of New Jersey;]

**By action of the House, upon recommendation of the Reference Committee, paragraph 3 was deleted— thereby causing paragraphs 4, 5, and 6 to be renumbered 3, 4, and 5. (page Tr 127)**

3. To receive inquiries, complaints, or accusations from any source concerning the professional conduct or ethical deportment of members of this Society for immediate reference to the appropriate county judicial committee.

**By action of the House upon recommendation of the Reference Committee, paragraph 3 was amended by the addition of the following sentence: "The jurisdiction of the Judicial Council extends to all members in all categories of membership within the Medical Society of New Jersey (page Tr 127)**

4. To receive, consider and rule on any matter of discipline concerning any member or members of this Society brought to it on appeal from a county judicial committee.

5. To make and promulgate from time to time such rules and regulations as in its opinion may be necessary to insure the proper functioning of the Judicial Council and the various county judicial committees with reference both to the substance and procedure of hearings conducted by the Judicial Council and such county judicial committees. Upon receipt of such rules and regulations by the various county judicial committees, the members of said committees shall be bound thereby.

## **Chapter V — Officers**

### **Section 1 — Term of Office**

- (a) The Officers, except the Judicial Councilors, the Secretary and Treasurer and the elected members of the Board of Trustees, shall hold office for one (1) year, or until their successors are elected and installed.

- (b) Notwithstanding any other provision of this Constitution or Bylaws, the elected Trustees, the Secretary, the Treasurer, and the members of the Judicial Council shall serve no more than three (3) three (3)—year terms in any of the above-mentioned offices or combination thereof.

### **Section 2 — Election**

The Officers shall be elected by ballot at the second session of the House of Delegates at the annual meeting. No member shall be eligible for more than one (1) office at the same time, except the President, the President-Elect, the First and Second Vice-Presidents, the Secretary, and the Treasurer, who by virtue of such offices are at the same time members of the Board of Trustees. A vacancy in office, except that of President-Elect, occurring between annual meetings may be filled by the Board of Trustees until the next regular election for the term and office being filled.

### **Section 3 — Rights and Duties of Officers**

- (a) — *The President*

The President shall preside at all meetings of this Society and at all sessions of the House of Delegates, unless he shall have appointed a Speaker as provided in the Bylaws.

He shall appoint committee members as provided in these Bylaws, and he shall be an ex-officio member of all committees except the Nominating Committee and Judicial Council.

He shall be the official spokesman of this Society, and shall perform such other duties and functions as custom and parliamentary usage may require.

*(b) — The President-Elect and the Vice-Presidents*

The President-Elect and the Vice-Presidents shall assist the President in the discharge of his duties and functions.

In the absence or disability of the President, his duties and functions shall devolve upon the other presidential officers in the order of their seniority.

In case of vacancy in the office of President, by death, resignation, or removal, the President's functions and duties shall devolve upon the other presidential officers in the order of their seniority, the President-Elect becoming President automatically. The office of President-Elect shall then remain vacant until the next regular election of the House of Delegates. In case a vacancy in the office of President recurs after being filled by the President-Elect, the presidency shall devolve upon the Vice-Presidents, in the order of their seniority. Such service on the parts of a presidential officer for a partial term as President shall not affect or diminish the regular presidential tenure.

*(c) — The Secretary*

The Secretary shall be the official custodian of the Constitution and Bylaws and of the records of this Society and its House of Delegates.

He shall attend all annual or special meetings of this Society and all sessions of its House of

Delegates; and he shall keep proper records thereof.

He shall issue official notice of all meetings, annual or special, of this Society or of its House of Delegates.

He shall notify Honorary Members of their election.

He shall require and receive from the secretaries of the component societies, a list of their representatives in the House of Delegates and on the Nominating Committee, and shall publish such lists as the House of Delegates or Board of Trustees may direct.

He shall require and receive from the secretaries of the component societies, a list of their officers immediately following election, and a list of their committee chairmen.

He shall be the sole custodian of the Official Seal of this Society and shall affix it to such documents as the Bylaws may require, or the House of Delegates, the Board of Trustees, or the President may direct.

He shall conduct such formal official correspondence in the corporate name of this Society as the House of Delegates, the Board of Trustees, or the President may direct.

He shall submit to the House of Delegates an annual report of the work of his office.

He shall furnish to the Board of Trustees or the President such information as may be necessary for this Society's business.

He shall perform such other functions as are specified in the Constitution and Bylaws.

He shall be entitled to reimbursement for expenses incurred in fulfillment of duties imposed by the Bylaws, or authorized by the House of Delegates, or the Board of Trustees.

*(d) — The Treasurer*

The Treasurer shall be under bond, at the ex-

pense of this Society, in such amount as may be required by the Board of Trustees.

He shall demand and receive all funds due this Society, and shall preserve all funds of this Society.

He shall receive requests and donations, and maintain a complete record thereof.

He shall not pay money out of the treasury except (1) in amounts as provided in the annual budget, upon voucher of the officer or committee responsible for the expenditure, or (2) in amounts as provided by resolution of the Board of Trustees and for which a voucher has been prepared. All such vouchers shall be approved and signed by the chairman of the Committee on Finance and Budget.

He shall render at each annual meeting of this Society a full statement of all transactions of the Treasurer's office.

He shall notify the proper office or committee chairman whenever ninety per cent (90%) of the annual appropriation for any office or committee has been expended.

He shall collect and enter proper credits for per capita assessments received from component societies.

He shall perform such other duties as may be assigned by the House of Delegates or the Board of Trustees.

He shall submit his accounts for audit at such times as the House of Delegates or the Board of Trustees may order.

*(e) — Term of Office*

All Officers shall assume office at the close of the last session of the House of Delegates of the annual meeting at which they are elected.

*(f) — Resignation or Removal*

Any Officer of this Society may resign. He may be removed from office by action of the House

of Delegates, if found guilty by that body of neglect of duty, improper conduct, or violation of the Constitution and Bylaws. A two-thirds (2/3) vote of the delegates present and voting shall be required to effect such removal.

**Chapter VI — Other Delegates and Representatives**

Delegates and Alternate Delegates to other medical organizations shall be elected in accordance with the provisions of these Bylaws.

*(a) — American Medical Association*

The terms of office of Delegates and Alternate Delegates shall begin on January first of the year following their election, and shall continue for two (2) years, ending on the second December 31 thereafter.

**By action of the House upon recommendation of the Reference Committee the following sentence was added to sub-paragraph (a): "A member may be elected to this office any number of times until he or she reaches age 65." (page Tr 127)**

In the absence of any Delegate, any Alternate Delegate shall be eligible to serve.

[No member shall serve more than three two-year terms as an AMA Delegate. Likewise, no member shall serve more than three two-year terms as an Alternate Delegate.]

**In conformity with action taken by the House by an addition to the first paragraph under (a), the above paragraph is deleted.**

*(b) — Other Medical Organizations*

When representation has been recommended by the Board of Trustees and approved by the House of Delegates, such Delegates and Alternate Delegates shall be elected for terms of one (1) year.

*(c) — Representatives*

Official representatives from this Society to other organizations shall be appointed by the Board of Trustees or by the President with the approval of the Board of Trustees. Their functions and terms shall not exceed those set forth in their official notice of appointment.



## Chapter VII — Meetings

### (a) — *Annual Meeting*

The annual meeting shall be held at a time and place fixed by the House of Delegates or the Board of Trustees.

### (b) — *Special Meetings*

Special meetings of this Society or of the House of Delegates shall be called by the President upon the request of the Board of Trustees, or upon the request of the House of Delegates while in session, or upon the written petition of at least five per cent (5%) of the membership of this Society representing at least ten per cent (10%) of the membership of each of four (4) or more component societies.

### (c) — *Rules of Order*

The deliberations of this Society shall be governed by parliamentary usage as contained in the latest revision of Sturgis' "Standard Code of Parliamentary Procedure," when not in conflict with the Constitution and Bylaws.

### (d) — *Registration and Identification*

Each delegate and member in any category in attendance at an annual or special meeting of this Society shall properly complete an official registration card which he shall present at the registration desk. Failing to do so, he shall be considered absent. Upon verification by the Reference Committee on Credentials of his right to register, he shall receive a certificate or badge designating his status.

### (e) — *General Sessions and Section Meetings*

#### (1) — *General Sessions*

All registered members may attend and participate in the proceedings and discussions of the general sessions and section meetings. Upon invitation other registrants may attend. The general sessions shall be for the presentation of the addresses of the President, President-Elect, invited guests, and scientific papers and timely discussions, as provided in the official program.

These sessions shall be presided over by the President, President-Elect, or one of the Vice-Presidents.

#### (2) — *Section Meetings*

(a) Section meetings shall be for the presentation of scientific papers and discussions related to the sections designated and as provided in the program.

(b) Each section shall have a chairman and a secretary, who shall serve for one (1) meeting, after which the secretary shall become the chairman for the next meeting of the section. The secretary for the next meeting shall be selected during the business meeting, for which at least ten (10) minutes shall be scheduled in the program for each section meeting.

(c) The chairman shall preside at the section meeting. The section program shall be prepared under the guidance of the chairman, with the final program subject to the approval of the Committee on Annual Meeting.

(d) At a regularly scheduled session meeting committees may be established for scientific investigations of special interest or of importance to the profession or public. No expense to this Society shall be incurred in connection therewith unless authorized by the House of Delegates and approved by the Board of Trustees.

#### (3) — *Length of Addresses*

No address or paper, with the exception of those delivered by the President, President-Elect, and invited guest speakers, shall take more than twenty (20) minutes for presentation; and no discussor shall speak longer than five (5) minutes, nor more than once, on any subject, unless by permission of the presiding officer.

#### (4) — *Ownership of Papers*

All papers and reports presented to this Society shall become its property, and when read shall be deposited with the Secretary. Permission to publish such papers in *The Journal* of this

Society or in other medical journals may be granted by the Committee on Publication.

#### (5) — *Guests*

Upon invitation extended by this Society or any of its members, any person may become a guest during the annual meeting. Physician guests are entitled to attend the general sessions and section meetings. Non-physician guests may attend the general sessions, but may attend a section meeting only with the permission of the presiding officer of that section.

### **Chapter VIII — Procedure of Election**

#### **Section 1 — Nominating Committee**

(a) Each component society shall elect, at any meeting prior to March 31 of the fiscal year, one (1) of its elected delegates to serve as a member of the Nominating Committee at the next annual meeting of this Society. At the same time, each component society shall elect one (1) of its elected delegates to serve as the alternate member of the Nominating Committee.

(b) The elected member of the Nominating Committee, or in his absence the alternate member of the Nominating Committee, shall present his credentials to the Secretary before the scheduled meeting of the Nominating Committee.

(c) The Immediate Past-President of this Society shall be a member of the Nominating Committee representing the Fellows and shall serve as Chairman.

(d) The nominating delegates, or their alternates, and the representative of the Fellows shall comprise the Nominating Committee. The Committee shall be required to meet at least forty (40) days prior to the opening session of the Annual Meeting of the House of Delegates. Its report of nominations for the offices being filled shall be mailed with the advance materials to the delegates and shall be printed in the *Membership Newsletter* and *The Journal* prior to the Annual Meeting.

#### **Section 2 — Procedure of Nomination**

(a) The chairman of the Nominating Committee shall be the Immediate Past-President of this Society, or, in the event he is unable or unwilling to serve, a member designated by the Fellows. The committee shall elect one (1) of its own members to serve as Secretary, who shall call the roll of accredited members of the committee as certified by the Secretary of this Society.

The chairman shall read to the committee this section of the Bylaws (Chapter VIII, Section 2) before proceeding to any other business.

(b) The Secretary of this Society shall furnish to the committee such information as is necessary for the proper conduct of its business, including a list of all offices to be filled.

(c) The Nominating Committee meeting shall be conducted in accordance with Sturgis' "Standard Code of Parliamentary Procedure." No candidate shall be considered by the Nominating Committee unless a curriculum vitae in conformity with the form utilized by MSNJ for those seeking elective office is available to the Nominating Committee.

(d) A majority vote of the members present shall nominate.

#### **Section 3 — Report and Election**

(a) The report of the Nominating Committee, the submission of nominations from the floor by members of the House of Delegates—if any—and the election shall constitute the principal business of the second session of the House of Delegates.

(b) All elections shall be by ballot, and a majority of the votes cast shall be necessary to elect.

(c) In the event that no candidate has received a majority of the votes cast, the name of the candidate receiving the least number of votes shall be dropped. Balloting shall be repeated until an election is made.

(d) When an incumbent elected officer, as defined in Chapter V, Section 2 of the Bylaws, is elected to serve as an officer in another capacity, the presiding officer shall then declare the previous elective office vacant. This vacancy shall then be filled immediately by nomination from the floor and election by the House of Delegates.

(e) The President-Elect shall advance to the office of President without process of nomination and election.

## **Chapter IX — Administrative Councils and Committees**

### **Section 1 — Classification**

There shall be Administrative Councils, Standing Committees, Reference Committees, and Special Committees.

### **Section 2 — Qualifications, Selections and Terms of Members**

(a) Only regular members of the Medical Society of New Jersey may serve on an administrative council or committee.

(b) Reference Committee members shall be appointed by the President and must be members of the House of Delegates elected by their respective component societies.

(c) The President shall designate the Chairman and Vice-Chairman of each administrative council and the various committees. The President shall be an ex-officio member of all administrative councils and committees except the Nominating Committee and the Judicial Council.

(d) Unless otherwise stipulated in these Bylaws or in the action creating a special committee, the term of service thereon shall be limited to three, three-year terms. Interim appointments and unexpired terms are not to be computed in determining the tenure of any member.

(e) Members of councils and committees who have failed to discharge their duties in a satisfactory fashion may be removed by the Board of Trustees and the President may fill the resulting vacancy.

## **Section 3 — Administrative Councils, Standing Committees and Special Committees**

(a) The administrative councils and standing committees shall be as listed below. In addition to projects of their own initiations, they shall perform such functions and duties as are assigned to them by the Board of Trustees and the House of Delegates. Their recommendations shall be subject to the approval of the Board of Trustees.

### **1. Council on Legislation**

The Council on Legislation shall consist of twelve members, six of whom shall be elected by the House of Delegates and six to be appointed by the President. There shall be at least one elected and one appointed member from each judicial district. The Chairman of the Board of Trustees shall be an ex-officio member of the Council on Legislation.

### **2. Council on Medical Services**

The Council on Medical Services shall consist of twelve members, six of whom shall be elected by the House of Delegates, and six appointed by the President. There shall be at least one elected and one appointed member from each judicial district. The President-Elect shall serve as an ex-officio member of the Council on Medical Services.

### **3. Council on Mental Health**

The Council on Mental Health shall consist of twelve members, six of whom shall be elected by the House of Delegates, and six appointed by the President. There shall be at least one elected and one appointed member from each judicial district. The Immediate Past-President shall be an ex-officio member of the Council on Mental Health.

### **4. Council on Public Health**

The Council on Public Health shall consist of twelve members, six of whom shall be elected by the House of Delegates, and six appointed by the President. There shall be at least one elected and one appointed member from each judicial district. The First Vice-President shall be an ex-officio member of the Council on Public Health.



#### **5. Council on Public Relations**

The Council on Public Relations shall consist of twelve members six of whom shall be elected by the House of Delegates, and six appointed by the President. There shall be at least one elected and one appointed member from each judicial district. The Second Vice-President shall be an ex-officio member of the Council on Public Relations.

#### **6. Committee on Annual Meeting**

The Committee on Annual Meeting shall consist of six members, three of whom shall be elected by the House of Delegates, and three appointed by the President. The Secretary shall be an ex-officio member of this Committee.

#### **7. Committee on Credentials**

The Committee on Credentials shall consist of seven members, six of whom shall be appointed by the President. The seventh member shall be the Secretary of the Society who also shall serve as Chairman of this Committee.

#### **8. Committee on Finance and Budget**

The Committee on Finance and Budget shall consist of six members, three elected by and from the House of Delegates, and three elected by and from the Board of Trustees. The Committee shall control the expenditure of funds and the development of the Annual Budget for submission to the House of Delegates. The Treasurer shall be an ex-officio member of this Committee.

#### **9. Committee on Medical Defense and Insurance**

The Committee on Medical Defense and Insurance shall consist of six members, three of whom shall be elected by the House of Delegates, and three appointed by the President. The Secretary shall serve as an ex-officio member of this Committee.

#### **10. Committee on Medical Education**

The Committee on Medical Education shall consist of six members, three of whom shall be elected by the House of Delegates, and three appointed by the President.

#### **11. Committee on Medical Student Loan Fund**

The Committee on Medical Student Loan Fund shall consist of five members appointed by the President.

#### **12. Committee on Physicians' Relief Fund**

Item 12. "Committee on Physicians' Relief Fund" was deleted in accordance with IRS ruling that the Fund was in violation of 501-(c)-(6) Non-Profit Status of MSNJ. (See pages Tr 35, Tr 86, and Tr 131) The following paragraphs thus are renumbered as follows:

#### **12. Committee on Publication**

The Committee on Publication shall consist of three members elected by the House of Delegates. The President-Elect, the Secretary, and the Editor of *The Journal* shall be ex-officio members of the Committee on Publication.

#### **13. Committee on Revision of Constitution and Bylaws**

The Committee on Revision of Constitution and Bylaws shall consist of six members appointed by the President. The Secretary shall be an ex-officio member of the Committee.

#### **14. Advisory Committee to the Auxiliary**

The Advisory Committee to the Auxiliary shall consist of six members, three of whom shall be elected by the House of Delegates, and three appointed by the President.

#### **15. Special Committees**

Special Committees may be created by the House of Delegates or the Board of Trustees. They shall be appointed by the President. Their function and duration shall be clearly defined.

#### **16. Reference Committees**

Such Reference Committees as are deemed necessary by the President shall be appointed by him. All business coming before the consideration of the House of Delegates must first be considered by the appropriate Reference Committee unless the House of Delegates constitutes itself as a committee of the whole.

Reference Committees shall have plenary jur-

isdiction on the items referred to them. Their reports are subject to the final approval of the House of Delegates. They may not, however, make amendments or alterations to reports that are solely informative in nature and do not call for specific approval of the House.

## **Chapter X — Finance**

### **Section 1 — Annual Assessment (Dues)**

**By action of the House, upon recommendation of the Reference Committee, the word "Dues" in parentheses will follow "Annual Assessment." (page Tr 127)**

(a) By the first day of January in each year, each component society shall be officially informed of the per capita assessment levied by the House of Delegates. Payment of this assessment shall be forwarded to the Treasurer of this Society not later than five (5) days before the first of March, together with a list of the members for whom such payment is made.

(b) Per capita assessments shall apply in the same manner immediately upon the admission or reinstatement of members, except that for a new member admitted after September first of any calendar year, only one-half (½) of the regular per capita assessment shall be levied. Every member for whom the per capita assessment is paid shall be entitled to receive such publications as may be issued by this Society for its members.

(c) If a member has not paid his annual assessment by June first, his name shall be dropped from the membership rolls.

(d) The annual assessment of a component society shall not be less than the per capita assessment of at least ten (10) members, the smallest number to whom a charter may be granted to form a component society.

(e) This assessment shall not be levied against any member in good standing if:

(1) he shall have attained the age of seventy (70) years; or

(2) he is serving with the armed forces of the United States; or

(3) he is a member emeritus; or

(4) the payment of the assessment would be a financial hardship by reason of physical disability or illness. A member also may be excused from payment of the assessment because of financial hardship for other reasons, but these reasons must be set forth annually by the Secretary of the member's component society.

### **Section 2 — Per Capita Assessment**

(a) At the call of the chairman of the Committee on Finance and Budget, officers and committee chairmen shall submit an itemized estimate of the amount of money necessary for their official or committee's activities during the next fiscal year.

(b) The Committee on Finance and Budget shall then proceed to consider and determine the amount of money to be raised by the per capita assessment to be levied on the component societies.

(c) The recommendations of the Committee on Finance and Budget shall be reported to the House of Delegates at the first session of that body, together with any recommendations of the Board of Trustees after review.

(d) The House of Delegates may approve, amend, or reject the report, but final action on it shall not be taken until the last session of that body.

### **Section 3 — Annual Budget**

(a) No officer or committee may spend more money than the amount allowed in the budget. The Board of Trustees may, however, apportion to any officer or committee, on application, any unexpended balance from other items, provided that the total annual budget voted by the House of Delegates is not thereby exceeded.

(b) The Board of Trustees shall have the power to authorize the expenditure of funds in excess of budgetary appropriations in accordance with these Bylaws.

### **Section 4 — Fiscal Year**

The fiscal year of this Society shall extend from

the first day of June through the thirty-first day of May. The audit report, budget estimates, and appropriations shall likewise be for the same period.

### **Section 5 — Special Assessments**

Special assessments other than those necessary to fund the Annual Budget may be considered by the House of Delegates at any meeting of the House of Delegates and if adopted by the House shall become the obligation of all dues-paying members in such forms and amounts as the House shall declare. Unless otherwise stipulated by the House, delinquency in regard to a special assessment shall be treated in the same fashion as delinquency in the annual assessment.

## **Chapter XI — Component Societies**

### **Section 1 — Charters**

(a) County medical societies of this State that shall adopt principles of organization in accord with the Constitution and Bylaws of this Society may, upon application to the House of Delegates, be granted a charter, and thereby become a component society in affiliation with the Medical Society of New Jersey as hereinafter provided.

(b) Charters may be issued, under the seal of this Society and signed by the President and the Secretary, to county societies having at least ten (10) members. There shall be only one (1) component society chartered in each county. Upon recommendation of the Judicial Council, the House of Delegates may revoke the charter of any component society whose actions are in conflict with the letter or spirit of the Constitution and Bylaws.

### **Section 2 — Qualifications of Members**

(a) Component societies shall have the responsibility to judge the qualifications of an applicant for any type of membership and alone shall have the power to elect him, but election thereto shall be contingent upon clearance of each eligible applicant's formal credentials as satisfactory by the Committee on Credentials of this Society.

(b) To be eligible for membership, the applicant must:

[ (1) hold a degree in medicine or osteopathy acceptable to this Society obtained from a professional school approved by this Society at the time of his graduation;]

*By action of the House, upon recommendation of the Reference Committee, paragraph 1 was deleted, thereby causing paragraphs 2, 3, 4, and 5 to be renumbered 1, 2, 3, and 4. (page Tr 128)*

(1) be fully licensed to practice medicine and surgery by the New Jersey State Board of Medical Examiners;

(2) be legally registered under that license in a county of New Jersey;

(3) be of good moral and ethical standing; and

(4) not support, or practice, or claim to practice any exclusive system of medicine.

(c) When a physician applies to a component society for membership in any category, or for membership by transfer from another state, the secretary of the component society shall forward the name and address of the applicant to the biographic department of the American Medical Association for such information as may be on file relative to the applicant's record.

(d) All records of formal actions concerning new and transfer members shall be compiled on forms to be supplied by the Committee on Credentials.

(e) In order to retain active membership in this Society the member must hold a current Certificate in Continuing Medical Education from MSNJ's Committee on Medical Education. This certificate will be bestowed upon members who complete acceptable programs of continuing education for a total of 150 hours in a given three-year period. This program is to be administered by the Committee on Medical Education in accordance with policy approved by the Board of Trustees and affirmed by the House of Delegates. The Committee on Medical Education may, with the approval of the Board of Trustees, and for good cause shown, grant specific exemptions to this subsection.



### **Section 3 — Transfers**

An applicant for membership by transfer who holds membership in a component society in this or another state society and whose credentials have been formally approved may be elected to membership without a probationary period, at the discretion of the component society.

### **Section 4 — Associate Members**

(a) Associate members shall be those physicians admitted to component societies who otherwise comply with Section 2 of this Chapter but are not licensed to practice medicine and surgery in New Jersey but are serving in approved internship or residency programs.

(b) Associate members shall have such privileges in component societies as the constitution and bylaws of the respective societies may provide, except the right to vote and hold office.

(c) The dues for associate members shall be established by the House of Delegates on recommendation of the Committee on Finance and Budget.

### **Section 5 — Jurisdiction**

(a) Ordinarily a physician will hold member-

ship in the component society of the county in which he practices. However, with the permission of that component society, he may for reasons of convenience be a member of some other component society.

(b) No physician may be a member of two (2) component societies at the same time.

### **Section 6 — Resignations**

Resignations of members will be accepted as a matter of course if all financial obligations of the member to this Society and the appropriate component society have been met and there are no unresolved complaints pending before the judicial mechanism.

### **Chapter XII — Amendments to the Bylaws**

These Bylaws may be amended on the approval of two-thirds (2/3) of the House of Delegates present and voting at any meeting of the House of Delegates. A proposed amendment shall not be acted on, however, until it has been considered and reported on by the Standing Committee on Revision of Constitution and Bylaws. Amendments to the Bylaws shall be considered only during the report of the Reference Committee on Constitution and Bylaws.

**Adopted as amended (page Tr 127)**

## MSNJ Auxiliary Advisory

William J. Roe, M.D., Chairman, Englewood

(Reference Committee "H")

At its July 1976 meeting the Board of Trustees approved the Proposed Program of the Medical Society of New Jersey Auxiliary for 1976-77 as submitted. There was no need for a formal meeting of this Committee during the course of the administrative year.

Administrative and routine duties as outlined in the Bylaws of the Medical Society of New Jersey Auxiliary were accomplished. Full minutes are preserved in the archives.

Actions felt to be significant or of a general interest are as follows:

(1) Priorities included emphasis on membership and legislation, community and family health, health manpower careers, and improving health education in the school system.

(2) Adopted the recommendation of the Medical Society's Committee on Medical Student Loan Fund to make this Fund a priority project for 1976-77. Through the untiring efforts of the Auxiliary's Medical Student Loan Fund chairman and the county auxiliaries a substantial

contribution has been made to the Medical Student Loan Fund.

(3) Co-sponsored the state-wide eye health screening program.

(4) Auxilians volunteered and worked on the swine flu inoculation program in their respective counties.

(5) Conducted a Fall Workshop which consisted of "mini workshops" and Dr. Donald Noone's presentation of a leadership conference.

(6) Legsline program continued; Participated in — Legislation Seminar, Washington, D.C.; AMA Education Research Foundation Workshop in Chicago.

(7) Maintained liaison with the Medical Society's own Medical Student Loan Fund, Council on Legislation, JEMPAC, and the College of Medicine and Dentistry.

**Filed (page Tr 141)**

# Administrative Council

## Legislation

Meyer L. Abrams, M.D., Chairman, Cherry Hill  
(Reference Committee "E")

This report presents a summary of the ultimate status of legislative measures of primary concern to the Society in the 1976-77 Legislature.

The Council's operations, together with a cumulative report of MSNJ official positions on current legislation, are reflected regularly in official bulletins dispatched to State Legislative Keymen and to component societies, and in items published in the *Membership Newsletter* and *The Journal*. The minutes of the meetings of the Board of Trustees include full reports of the Council's actions taken in regular meetings.

The Council on Legislation continues its established policy of inviting an official representative from each specialty society to all Council meetings.

Although a notice announcing the date of each of the Council's meetings is sent to all MSNJ's official intermediaries with New Jersey specialty societies, the attendance of those representatives at the Council meetings remains small. The Council urges that more representatives attend its meetings so that it may have the benefit of the timely thinking of specialty societies concerning proposed legislation affecting the specialty fields.

The Council on Legislation agreed that in order to fortify our stand on legislative bills and make our position known throughout the Society that it be a standing policy to invite the chairman of each Council and Standing Committee to attend the legislative meetings and to give them the right, if they cannot attend, to select a representative.

Of the bills reported to the House in 1976, the following were signed into law:

### ACTIVE SUPPORT

S-1249 — To appropriate \$600,000 to the College of Medicine and Dentistry for the South Jersey medical program.

### APPROVED

S-152 — To define "dwelling" in the law prohibiting the use of lead paint to include day-care centers and nursery schools.

### DISAPPROVED

A-1455 — To amend the "New Jersey Medical Assistance and Health Services Act," to increase criminal penalties and to provide for recovery of excessive reimbursements.

The following bills of medical interest were introduced in the 1976 Legislature, but too late to be reported to the 1976 House of Delegates:

### S-1472 — *Mental Health Treatment*

This bill is one of an impending package of four, which are to be evolved as a result of a special committee study. It deals with the topic of assuring that confined patients receive care and treatment more than mere custody. It would create within Institutions and Agencies:

1. Mental Treatment Standards Committee which will consist of 9 members; two of whom would be certified psychiatrists. The other 7 could, indeed, be non-physicians. The Committee shall prepare a "Manual of Adequate Standards for Treatment of the Mentally Ill in State and County Mental Institutions", which will include, but not be limited to, definitive minimum treatments.

2. Patient Treatment Review Board—two of the five members would be MD's. The Board would receive, hear, and investigate complaints from patients concerning inadequate treatment and would recommend to the Commissioner of Institutions and Agencies action to compel adequate treatment.

Obviously, this bill is far-reaching and could have a devastating impact. *DISAPPROVED*, because although the concept of "assuring that confined patients receive care and treatment (rather than) mere custody" is laudable, the proposed membership of the Mental Treatment Standards Committee does not assure sufficient psychiatric participation to accomplish the proposed objective. Further, the Quality Assurance Programs of the Joint Commission on Accreditation of Psychiatric Facilities and the PSRO's may be expected to solve the problem.

### S-1512 — *Professional Boards*

This bill provides for one public member for every 5 regular members on the licensing boards.



(Would eliminate the public and executive department member whose appointment is currently provided for in P.L. 1971, c.60 (C.45:1-2.2).) The State Board of Medical Examiners would be reduced to 13 MD's, 1 DO, 1 chiropractor, 1 podiatrist, 1 bio-analytical laboratory director, plus the 2 public members. *APPROVED*

**S-1540 — Cancer Research**

Provides for a 1¢ per package tax on cigarettes. Money to be disbursed by the Commissioner of Health to institutes operated by the College of Medicine and Dentistry of New Jersey and Rutgers University and others. *APPROVED*

**S-1595 — Payment of Defense Costs and Attorney's Fees for Frivolous Suits Against Certain Professionals.** This bill does not directly affect the medical profession. However, it would permit architects, engineers, contractors, and land surveyors who are improperly named in suits to recover the costs of defense when the court upon motion finds the action to be "frivolous or vexatious." (With a subtle amendment to include physicians, a significant step forward could be made to temper the rate of claim assertion in medical professional liability actions.) *CONDITIONAL APPROVAL*—if the bill is amended to include physicians then change to *ACTIVE SUPPORT*.

**\*S-1674 — Menza, et al. — Mental Health**

Creates within Institutions and Agencies a Division of Mental Health Legal Counseling and Assistance. The substantive action of the bill goes beyond that title, however, since Division personnel will become involved in rendering advice to patients in any matter related to diagnosis, treatment, and care, including consents, denials, facility transfers, etc. *ACTION DEFERRED*, pending further information from the Council on Mental Health.

**\*S-1675 — Menza, et al. — Competency to Stand Trial**

This bill is designed to produce a format detailing when an individual is competent to stand criminal trial. Along with its companion bill *S-1676* which addresses the issue of culpability, it produces a drastic departure from existing case law and would recognize the theoretical defense of "irresistible impulse."

A major difficulty is that both bills equate the psychiatrist and the psychologist and would restrict participation as "experts" to those disciplines. *ACTION DEFERRED*, pending further information from the Council on Mental Health.

**\*S-1676 — Menza, et al. — Criminal Responsibility** (See *S-1675* for description.) *ACTION DEFERRED*, pending further information from the Council on Mental Health.

**\*S-1677 — Menza, et al. — Involuntary Civil Commitment** The final component of a four-bill package, this proposal again equates psychiatrists and psychologists and excludes all other medical and surgical disciplines.

Another glaring defect is that mental disorders produced by a primary disease process such as alcohol or drug dependence are not considered grounds for an involuntary commitment proceeding under this bill. *ACTION DEFERRED*, pending further information from the Council on Mental Health.

**S-1679 — McGahn — Optometric Referrals to Ophthalmologists**

This bill redefines optometry to require the optometrists to refer certain patients for ophthalmological studies. A major defect in this bill is that in any one of the six listed occasions a physician other than an ophthalmologist might, indeed, be a more proper referral. *CONDITIONAL APPROVAL*, subject to submitted amendments to the bill.

**A-1953 — Transportation of Radioactive Materials**

Amends Title 26 to prohibit the transportation of radioactive materials without the prior approval of the Commissioner of Environmental Protection.

Threshold limits are:

- a) Plutonium isotopes exceeding 2 grams or 20 curies;
- b) U-235 exceeding 25 atomic per cent of the total uranium content where the U-235 content exceeds one kilogram;
- c) Any actinides exceeding 20 curies;
- d) Mixed fission, waste products; spent fuel elements exceeding 20 curies; and
- e) Any quantity of radioactive material defined as a "Large Quantity" in 10 CFR Part 71. *ACTION DEFERRED*, pending a final report from the Radiological Society.

**A-1973 — Living Will**

Provides that persons over 18 may execute legal documents directing that in the event of a terminal illness no maintenance medical treatment may be utilized to prolong life.

"Terminal illness" is certified to in writing by the attending physician.

Physicians certifying terminal illness or relying upon the instruction of the executed document are immune from civil or criminal liability if acting in good faith. *NO ACTION*

**A-1999 — Blue Shield Coverage of Alcoholism**

Requires MSP to offer group contractees optional riders for coverage of alcoholism treatment. *APPROVED*

**A-2001 — Blue Cross Coverage of Alcoholism**

Requires HSP to offer group contractees optional riders for coverage of alcoholism treatment. *APPROVED*

**A-2021 — Generic Substitution and Advertising of Prescription Drugs**

Allows for the generic substitution of prescribed

\*For MSNJ's final position see page Tr 67

items where the physician fails to indicate "do not substitute." The physician would be at all times in control of the prescription process. Also amends current law prohibiting the advertising of drug products. *APPROVED*

**\*A-2032 — Physician-Dentist Loan Redemption Plan**

Makes available to CMDNJ students a loan redemption formula for service in areas of the State designated by the Department of Health as underserved—1 yr., 30%; 2 yr., 30%; 3 yr., 25%—85% is the total write-off permitted. *ACTION DEFERRED*, pending amendments now being made to this bill.

**A-2054 — Radiologic Technologists**

Outside of a change in terminology from technician to "technologist" the significant changes in current law are:

1. Restricts training programs to the hospital setting;
2. Eliminates the issuance of limited certificates for chest radiography.

*ACTION DEFERRED*, pending recommended changes in the wording of the bill to be submitted by the Radiological Society.

**A-2058 — Jersey City Medical Center**

Appropriates \$4 million for the support of the Jersey City Medical Center. *APPROVED*

**A-2107 — New Jersey Dental Practice Act**

Amends the existing Dental Practice Act. A major problem area is paragraph 15 which allows dentists to conduct physical evaluations of "the patient in connection with dental treatment, and may sign a death certificate when death has occurred in connection with dental practice." *NO ACTION* if amendment is effected; *DISAPPROVAL*, if amendment is not effected. (Amendment—deletes that portion of the bill referring to a dentist signing the death certificate.)

**A-2110 — Department of Health, Division of Consumer Health Services**

Legislates a Division which exists under current law by action of the commissioner. Transfers all inspection authority *vis-a-vis* sanitary conditions of government facilities to the Division.

Other changes related to due process in inspecting retail food establishments are also included. *APPROVED*

**A-2204 — This bill grants immunity from liability to public entities, public employees, and volunteer personnel (including physicians) participating in the A/New Jersey/76 Immunization Program. *APPROVED***

Filed (page Tr 135)

**Note: Reference Committee "E" felt that legislative committees frequently are not provided sufficient and accurate**

information from physicians which could influence pending legislation in a more favorable way. There is a disconcerting absence of physicians at legislative hearings. It was recommended that more effective leadership be established in promoting attendance at such hearings by informed members of the Society.

## Supplemental #1

The following is the official position of bills previously reported as *Action Deferred*:

S-93 — To authorize the State Board of Higher Education to contract with Fairleigh Dickinson University School of Dentistry for acceptance of New Jersey students. *APPROVED*

S-100 — To amend the Practicing Psychology Licensing Act in several respects concerning membership on the Board, license fees, and continuing education requirements. *DISAPPROVED*, because no licensing board should be composed purely of licensed practicing professionals.

S-318 — To provide for the involuntary commitment of persons believed to be mentally ill. *NO ACTION*

S-324 — To require county mental health boards to create the position of mental health administrator. *NO ACTION*

S-327 — To permit health insurance coverage, other than group and blanket, for outpatient treatment of the mentally ill. *DISAPPROVED*, because the bill does not indicate clearly the scope of coverage or eligible providers.

S-328 — To permit group and blanket health insurance coverage for outpatient treatment for the mentally ill. *DISAPPROVED*, because the bill does not indicate clearly the scope of coverage or eligible providers.

S-329 — To permit hospital service corporations to make coverage available for outpatient treatment of the mentally ill. *DISAPPROVED*, because the bill does not indicate clearly the scope of coverage or eligible providers.

S-485 — To prohibit the addition of fluorides to any municipal water supply where total fluorides from all sources in the environment exceed an average of 1.2 milligrams per day per person and to require the Department of Environmental Protection to survey all areas of the State for environmental fluorides content. *APPROVED*

S-615 — To require all group health insurance policies to provide benefits at least equal in value to 60 days hospitalization for mental health illness. *DISAPPROVED*, because the wording used would

\*For MSNJ's final position see page Tr 68

create only the facade of coverage. It is virtually impossible to say that a given psychiatric disorder is subject to "favorable modification by short term treatment."

- S-870 — To create and establish a risk register for handicapped and high-risk children in the Department of Health. *DISAPPROVED*, because this bill would be very costly to implement, with limited value to the public.
- S-902 — To authorize the State Board of Pharmacy to give consideration to the geographical needs in granting licenses to applicants and to permit establishment of minimum and maximum prices for prescription drugs. *NO ACTION*
- S-903 — To establish a permanent Mental Health Oversight Commission. *DISAPPROVED*, because current PSRO, JCAH, and state licensing standards more than adequately insure proper care.
- S-1139 — To revise the law regulating the practice of dentistry and dental hygiene. *DISAPPROVED*, because this bill would grant the Division of Consumer Affairs unparalleled regulatory discretion over the utilization and training of dental assistants, qualifications for specialized practice in dentistry, and licensing requirements. It would (in violation of constitutional rights) mandate that all dentists be required to service medicaid patients and the discretionary exercise of penal power by the Board and Division of Consumer Affairs has been made mandatory. In addition of expansion of powers conferred by particular sections of the act, "the Board is empowered to do any and all things which *may be appropriate* to achieve the objectives *contemplated* by the New Jersey Dental Practice Act, or which may be *useful* in executing any of the duties, powers or functions of the Board." Such an uncontrolled delegation of authority presents an opportunity for abuse by administrative agencies.
- S-1423 — To revise penalties for driving while intoxicated; to reduce .15% to .10% alcohol in defendant's blood to presume intoxication; to provide for a program of alcohol education or rehabilitation. *APPROVED*
- A-1250 — To require all group health insurance policies to provide benefits at least equal in value to 60 days hospitalization and \$1,000 or 50 percent of mental health expenses under major medical coverage. *DISAPPROVED*, because without definitive cost data it is unwise to broaden the scope of insurance coverages by legislative mandate.
- A-1251 — To require all group hospital service contracts to provide benefits at least equal in value to 60 days hospitalization as a result of mental illness. *DISAPPROVED*, because without definitive cost data it is unwise to broaden the scope of insurance coverages by legislative mandate.
- A-1252 — To require all group medical service contracts to provide benefits of at least \$1,000 or 50 percent

of mental health expenses under major medical coverage. *DISAPPROVED*, because without definitive cost data it is unwise to broaden the scope of insurance coverages by legislative mandate.

- A-1827 — To remove the licensing requirement for ophthalmic technicians. *CONDITIONAL APPROVAL*, provided the State Board of Examiners of Ophthalmic Dispensers includes an Ophthalmologist as one of its members.

On the afternoon of January 11, 1977, the Second Annual Session (1977) of the 197th New Jersey Legislature was opened. As the Legislature presently is constituted, the Senate has 40 members. The Senate is made up of 10 Republicans, 29 Democrats, and one Independent. The Assembly has 80 members, of whom 31 are Republicans and 48 are Democrats. One Assembly seat is vacant.

By means of legislative bulletins the Society's official positions on all current State Legislation are regularly called to the attention of legislators as well as component societies, cooperating agencies, county keymen, and county society secretaries and executive secretaries.

The Society has adopted the following regular range of official positions concerning proposed legislation:

ACTIVE SUPPORT . . . All-out support of the measure.

ACTIVE OPPOSITION . . . All-out opposition for the measure

CONDITIONAL APPROVAL . . . To indicate that the approval of the Society is conditional subject to the elimination of the unsatisfactory elements of the bill that are pointed out.

APPROVAL . . . Commended as satisfactory, but not actively supported.

DISAPPROVAL . . . Rejected as unsatisfactory but not actively opposed.

#### CURRENT STATE LEGISLATION

The Council offers this Supplemental Report #1 covering items dealt with since the compilation of its Annual Report.

Filed (page Tr 135)



*S-1674* — Menza, *et al.* — Mental Health — Creates within Institutions and Agencies a Division of Mental Health Legal Counseling and Assistance. The substantive action of the bill goes beyond that title, however, since Division personnel will become involved in rendering advice to patients in any matter related to diagnosis, treatment, and care including consents, denials, facility transfers, etc. *DISAPPROVED*, because persons neither capable of rendering mental health services nor legally licensed to do so will be rendering decisions in diagnosis and treatment. Currently developing PSRO and quality assurance programs are well suited to protect and foster appropriate patient care.

*S-1675* — Menza, *et al.* — Competency to Stand Trial — This bill is designed to produce a format detailing when an individual is competent to stand criminal trial. Along with its companion bill *S-1676* which addresses the issue of culpability it produces a drastic departure from existing case law and would recognize the theoretical defense of "irresistible impulse." *DISAPPROVED*, because the different background training and clinical experience of the psychiatrist and the psychologist result in two different kinds of expertise which cannot be equated either in terms of the diagnosis or treatment of illness.

*S-1676* — Menza, *et al.* — Criminal Responsibility — This bill is designed to produce a change in the definition of Criminal Responsibility. It produces a drastic departure from existing law and would recognize the defense of "irresistible impulse." This bill, as its companion bill *S-1675*, would equate the psychiatrist and the psychologist and would restrict expert testimony to those two disciplines. *DISAPPROVED* (same as *S-1675*)

*S-1677* — Menza, *et al.* — Involuntary Civil Commitment — (Because of extensive Senate Committee amendments it is suggested that the Board of Trustees refer this bill back to the Council on Legislation for further consideration).

*S-1687* — Dunn — Good Samaritan Act — This bill would amend the Good Samaritan Act to grant immunity to persons participating in mobile intensive care teams. *APPROVED*

*S-1706* — Beadleston — Early Detection of Hypothyroidism — This bill provides for a screening process for hypothyroidism in newborns. The State Department of Health is to institute and conduct all necessary laboratory tests. *ACTION DEFERRED*, pending further information from the Council on Public Health.

*S-1719* — Menza — An Act Establishing A Mental Treatment Standards Committee — The proposed committee will consist of 7 New Jersey residents, one psychiatric social worker, 2 psychiatrists, one psychiatric nurse, the Director of the Division of Mental Health and Hospitals, one administrator of a community mental health facility, and one licensed psychologist. The Committee

shall prepare a recommended "Manual of Adequate Standards for Treatment of the Mentally Ill in State Mental Institutions." The standards recommended by the Committee shall be expressed in as objective terms as possible. This also creates a Patient Treatment Review Board, consisting of one psychiatrist, one non-psychiatrist M.D., one licensed psychologist, one psychiatric R.N., and one licensed attorney. The Board shall review patient complaints and recommend such action as may be necessary to compel adequate treatment. *ACTION DEFERRED*, pending further information from the Council on Mental Health.

*S-1720* — Hagedorn, *et al.* — Creates a commission to inquire and study the spiraling costs of hospital care and to evaluate the effectiveness and existing cost containment. There is no provision for physician representation. *APPROVED*, with recommendation to the sponsor that *at least one physician* be appointed to the Commission.

*S-1747* — Russo — Smoking Within Health Care Facilities — Requires health care facilities to adopt policies regulating smoking, i.e., designated areas and prohibitions — public posting. *APPROVED*

*S-1748* — Russo — An Act concerning the Practice of Medicine and Surgery — Amends the existing advertising statutes to allow physicians to place reasonable signs within proximity of their offices, but not necessarily on the same building. *APPROVED*

*S-1751* — Martindell — Living Will — Provides that persons over 18 may execute legal documents directing that in the event of a terminal illness no maintenance medical treatment may be utilized to prolong life. "Terminal Illness" is certified to in writing by the attending physician. Physicians certifying terminal illness or relying upon the instruction of the executed document are immune from civil or criminal liability if acting in good faith. *NO ACTION*

*S-1758* — Skevin, McGahn, *et al.* — Cancer Incidence Registry — Declares cancer to be a reportable disease under the Public Health Council Statutes and requires the maintenance of a cancer incidence registry. *APPROVED*

*S-1801* — Russo — Motor Vehicles — Provides that all drivers of motor vehicles have given implied consents to blood and urine chemical tests to determine the presence of drugs or alcohol in the individual's system. Refusal to consent to the test involves an automatic suspension of driving privileges. *APPROVED*

*S-3022* — James Wallwork — Computerized Axial Tomography Unit — Requires physicians in private practice to acquire a Certificate of Need in order to purchase a CAT Scanner. *ACTIVE OPPOSITION*, because this bill poses an infringement upon the private practice of medicine.

*S-3034* — Skevin, McGahn, *et al.* — Cancer Detection — Authorizes the Commissioner of Health to develop a program for the detection, diagnosis and treatment of cancer, including research. Also provides for a "training program for paramedics in cancer detection." Appropriates \$500,000. *APPROVED*

*S-3035* — Skevin, McGahn, *et al.* — Establishes a "Cancer Control Act." Authorizes the Commissioner of Health and Environment with the approval of the "Cancer Control Council" (no physician representation—nor scientific for that matter) to regulate the manufacture, sale, and labeling of products which have a carcinogenetic effect. Appropriates \$500,000. *ACTION DEFERRED*, pending further information from the Committee on Cancer Control.

*S-3055* — McDonough — Professional Liability (Same as A-2375) — This bill was drafted by the Monmouth-Ocean Medical Society project. It contains a number of very favorable concepts which have thus far proved to be unacceptable to the legislature, i.e., an absolute two-year occurrence on the Statute of Limitations, a limitation on pain and suffering compensation which is recoverable only when caused by a willful or grossly negligent act, a limitation on punitive damages of \$100,000.

Other areas of difficulty are:

- (1) All providers of health care must carry professional liability insurance (limits are not specified).
- (2) Only when insurance covering liability is reasonably available as determined by the Commissioner shall a provider be liable for malpractice. (No Court, Legislature, or Regulator would allow this clause to be operative.)
- (3) Standards are directly correlated to PSRO geographic areas. Changes in PSRO areas would result in different standards and Federal repeal or amendment of PSRO may result in chaos. Also physicians practicing in more than one PSRO area would have a multiplicity of standards with which to comply. *ACTION DEFERRED*, pending the outcome of the current legislative session. (It was recommended that a letter be addressed to the Monmouth and Ocean County Medical Societies explaining the Society's position on this bill)

*S-3123* — Russo — Clarifies the Good Samaritan Act to clearly cover a call on an in-hospital emergency. *APPROVED*

*S-3125* — Imperiale, Davenport, Buehler, Bedell — Traditionally, the most complete and extensive courses of instruction in emergency services had been the "Five Point" system conducted by the American Red Cross, the National Safety Council and others. Recently a program of emergency training services has been implemented by the State which combines the elements of the "Five Point" system into one program. This State certification has now been accepted by first aid, rescue and ambulance squads to the point of exclusion of the

"Five Point" system. This bill would equate the two programs. *APPROVED*

*S-3140* — Martindell — This bill addresses the problem of the high cost of many prescription drugs by a twofold approach. It provides for the dispensing by pharmacists of lower-priced, generic substitutes for prescribed drugs in a strictly regulated manner, and authorizes the advertising of prescription drug prices. *APPROVED*

*A-1659* — Bassano — To require females to take serological tests, prior to issuance of a marriage license, to determine if they ever had rubella. *DISAPPROVED*, because this type of legislation is unwarranted, at this time, since in view of recent inoculations, only 17 reported instances of rubella-associated birth defects occurred in the U.S. last year.

*A-2032* — To establish a Physician-Dentist Loan Redemption Program for students of the College of Medicine and Dentistry and to appropriate \$20,000 for administrative costs. *CONDITIONAL APPROVAL*, pending suggested amendments.

*A-2242* — Visotcky — Requires prescribers of medications to indicate whether or not the nature of a drug should be indicated on the label and whether or not a generic equivalent can be dispensed. *APPROVED*

*A-2283* — Lefante — Chiropractic — Creates an independent board of chiropractic examiners—five licensed chiropractors and one public member. Would remove jurisdiction of the State Board of Medical Examiners. This bill does not alter the scope of chiropractic licensure. *ACTIVE OPPOSITION*, because the bill establishes a separate licensing board without demonstrating the need therefor.

*A-2356* — Froude — Restrictive Covenants — Precludes physicians and professional services' corporations from having an enforceable restrictive covenant upon termination of employment or withdrawal from a partnership. *APPROVED*

*A-2375* — Maguire, *et al.* — Professional Liability (Same as S-3055) — This bill was drafted by the Monmouth-Ocean Medical Society project. It contains a number of very favorable concepts which have thus far proved to be unacceptable to the legislature, i.e., an absolute two-year occurrence on the Statute of Limitations, a limitation on pain and suffering compensation which is recoverable only when caused by a willful or grossly negligent act, a limitation on punitive damages of \$100,000.

Other areas of difficulty are:

- (1) All providers of health care must carry professional liability insurance (limits not specified).
- (2) Only when insurance covering liability is reasonably available as determined by the Commissioner shall a provider be liable for malpractice. (No Court, Legislature, or Regulator

would allow this clause to be operative.)

(3) Standards are directly correlated to PSRO geographic areas. Changes in PSRO areas would result in different standards and repeal or amendment of PSRO may result in chaos. Also physicians practicing in more than one PSRO area would have multiplicity of standards with which to comply. *ACTION DEFERRED*, pending the outcome of the current legislative session. (It was recommended that a letter be addressed to the Monmouth and Ocean County Medical Societies explaining the Society's position on this bill)

A-2409 — Newman — Grants injured and ill employees the right to select their own physicians under the Workmen's Compensation Act. *APPROVED*

A-2419 — Doyle — This bill extends implied consent to blood specimens in situations when the police so request and the "operator is unconscious." *APPROVED*

A-3055 — Froude — Medicaid Reimbursement — Amends the Medicaid law to provide that providers who are private practitioners shall not be reimbursed at a different rate than providers who are "nonprofit agencies." *APPROVED*

A-3043 — Pellecchia — Medicaid Eligibility — Extends Medicaid coverage to the medical needy (those with an income 1-1/3 above categorical public assistance). Also amends the law to enable the Division of Medical Assistance to assess and collect incorrect or illegal payments and penalties

(currently a function of the courts). *CONDITIONAL APPROVAL*, pending further clarification of the bill regarding legal safeguard amendments i.e. due process, rights of individuals, etc.

A-3067 — Martin, *et al.* — Physician-Dentist Loan Redemption — Permits New Jersey students who are willing to serve in areas designated by the Commissioner of Health as "medically underserved" to redeem as much as 85% of their accumulated loan indebtedness for 3 years of service. There is an awesome amount of power placed in the hands of the Commissioner in regard to manpower distribution. Some of the provisos of this Act, if not carefully implemented, may run counter to the 1964 Civil Rights Act and the U.S. Constitution. *DISAPPROVED*, in favor of A-2032.

A-3068 — Jackman — Optometry — Declares as a violation of the licensing act the location of an optometric practice in such proximity to an optical establishment in a manner which confuses the consumer as to the independence of the optometric practice. *NO ACTION*

ACR-189 — Proposes to amend the New Jersey Constitution to provide that a majority of the members of the professional boards shall be members of the public and not engaged in the practice of the profession being regulated. (Does not affect the State Board of Bar Examiners or the State Supreme Court.) *CONDITIONAL APPROVAL*, provided all professions requiring licensure are included.

Filed (page Tr 135)



# Administrative Council

## Medical Services

Victor H. Boogdanian, M.D., Chairman, New Brunswick

(Reference Committee "F")

The Council is charged with the responsibility of studying and evaluating matters relevant to maintenance and advancement of standards and character of medical practices in New Jersey, and of investigating the economic and social aspects of medical care.

### AD HOC COMMITTEE ON NUTRITION

As a follow up to the survey of the fifty hospitals in New Jersey that have major roles in the teaching of dietitians, nurses, and physicians, the recommendations of the Inter-Agency Steering Committee were published in *Nutrition Today*. This same report will be published in *The Journal* in the near future.

A grant has been prepared to explore nutritional standards in hospitals. With this in mind, the Council on Medical Services approved the holding of an informational meeting between the Ad Hoc Committee on Nutrition and representatives from food service providers.

### PAYMENT BY BLUE SHIELD FOR MEDICAL CONSULTATION IN CONSULTANT'S OFFICE— RESOLUTION #30

This resolution was referred by the 1975 House of Delegates for consideration. Blue Shield has agreed to conduct a pilot study to ascertain the feasibility of providing such a coverage on a statewide basis. This pilot study would enable Blue Shield to develop structural guidelines to insure against misuse of this service, if provided statewide. Blue Shield is now setting up a one-year pilot study in Union County, allowing consultations in physicians' offices, which would enable them to make a more complete estimation on any savings resulting from such a program.

### JOURNAL INSERT—SURVEY OF MEMBERSHIP

The Council is in the process of working up a

survey concerning which subjects the membership thinks the Council should explore.

### COMPUTERIZED AXIAL TOMOGRAPHY UNITS

The Council on Medical Services recommended to the Board of Trustees that The Medical Society of New Jersey urge Commissioner Finley to keep the Proposed Standards for Axial Tomography as flexible as possible.

### RUBELLA IMMUNIZATION—A-1659

It was reported that there were 17 cases of children afflicted by rubella-connected birth defects in the nation last year. After further investigation, the Council strongly urged that The Medical Society of New Jersey not approve A-1659, requiring females to take serological tests to detect Rubella prior to issuance of a marriage license.

### THE ROLE OF FISCAL INTERMEDIARY IN REVIEWING MEDICAL CASES

The Council was asked to investigate the mechanism of rejection by Medicare fiscal intermediary agents of full payment to patients for physicians' charges. While agreeing the interspersing of third party decisions between patient and physician relationships are not desirable, the Council recognized the reality of the present Medicare law and its interpretation and implementation by the fiscal intermediary charged with administering it. After hearing the sequence of administrative levels at which adverse decisions were made, the Council was convinced that these decisions were not made arbitrarily or capriciously, nor by non-medical personnel. Note was also made of the appeal mechanism available to physicians for individual cases for the appropriate third party complaint committee and/or the peer review committee. Admittedly, the time and effort necessary to pursue correction of a presumed

inequity may seem wasteful, to both the physician and the third party. At the present time, however, it is a necessary burden and the only

forum we have to resolve differences among professionals.

**Filed (page Tr 137)**

## *Special Committee to Council on Medical Services*

### **Occupational Health, Workmen's Compensation, and Rehabilitation**

**Elmer J. Elias, M.D., Chairman, Trenton**

(Reference Committee "F")

The Committee resolved a complaint from a labor union against an employer to the satisfaction of all concerned. The Committee also considered the following items: the investigation of coverage for rehabilitation services for those who are covered only by Blue Cross; the

hiring of handicapped people; non-child-proof tops on medications. These matters are under continuing study.

**Filed (page Tr 137)**

# *Administrative Council*

## Mental Health

**Robert S. Garber, M.D., Chairman, Belle Mead**

(Reference Committee "F")

The bulk of our Council's time and energy was primarily invested this year in discussing the content of the so-called "Master Plan for Mental Health—State of New Jersey," as prepared by its Commission. Shortly following its appearance, there became evident a flurry of legislative bills to implement many of the proposals which required considerable study.

Our Council remains unanimous in its opposition to the Mental Health Reform Plan which suddenly has been decreed "The Road Map for the State of New Jersey's Mental Health" for years to come. It is apparent that the cart has been placed before the horse. In addition, many of the Committee's suggestions already have been implemented by the Department of Human Services; yet they continue to solicit reactions and rebuttals from various statewide organizations.

We have prepared our own rebuttal to this report and, with the grateful assistance of a grant from the Board of Trustees, hope to hire a professional staff person to do the final editorial work.

Of great concern to us, as with all medical professionals, is Senate Bill #1677 which would remove all physicians (excepting psychiatrists) from the privilege of completing a commitment blank for the involuntary admission of a patient to a psychiatric facility. It would stipulate that only psychiatrists, or a psychiatrist and a psychologist, could commit a patient. We are unalterably opposed to the bill since family practitioners, emergency room physicians, internists *et al.* would be prevented from promptly placing acutely disturbed patients into a hospital setting.

For the third straight year, our Council remains frustrated by the failure of the New Jersey State Board of Medical Examiners to act on our proposal for a model bill to deal with the impaired physician.

Finally, our concern for the future role of the Council appears diminished with the anticipated simultaneous loss of four long-term members who can serve no longer.

**Filed (page Tr 137)**



## *Administrative Council*

### **Public Health**

**Frederick C. Steller, M.D., Chairman, Spring Lake**

(Reference Committee "G")

The Council on Public Health and its many Committees had regularly scheduled meetings during the year—with good representation—to review the many topics under consideration.

At our 1976 Annual Meeting a resolution was passed: "To assist the Public Health Department in the implementation of the Swine Flu Program." The Council did assist the Public Health Department and forwarded to the Board of Trustees certain guidelines for our members to follow in the administration of the vaccine.

The Council reviewed the referral from the Board of Trustees in requesting the Commissioner of the Board of Education to submit to the Society a list of school physicians. Such a request was forwarded. We were informed that the New Jersey State Department of Education has no such list. Upon a second referral from the Board, the Council forwarded a similar request to the Association of School Physicians; to date there has been no answer.

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## *Special Committees to Council on Public Health*

### **Cancer Control**

**Roy T. Forsberg, M.D., Chairman, Elizabeth**

(Reference Committee "G")

The Committee on Cancer Control met on September 22, 1976 with Miss Katharine Heintz, Special Assistant to the Governor representing his Cabinet Committee on Cancer Control. We had offered the Society's support on all levels for whatever help was needed from us for the State of New Jersey. We have awaited with anticipation contact from the Governor's office for their cooperation but this has not been forthcoming.

The Chairman of this Committee has been appointed by our President, John Madara, to represent The Medical Society of New Jersey on the Scientific Advisory Committee of the Cancer Institute of New Jersey. There is no report to this committee at this time as we are now in the process of setting policy.

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## Child Health

**Glenn P. Lambert, M.D., Chairman, Flemington**

(Reference Committee "G")

The Committee met in December, 1976, with Dr. Earl F. Hoerner, Chairman of the Amateur Hockey Association of the United States Safety and Protective Equipment Committee, in an effort to establish a Medical Advisory Group in Sports Medicine, bringing together interested physicians, athletic trainers, school principals, superintendents, and athletic coaches to deal with a wide range of aspects of athletics in secondary schools. The committee recommended that a working advisory committee be formed, composed of representatives from the Society as well as other groups such as the Coaches' Association, Trainers' Association, and consumers' groups who act as catalyst, making itself available to identify problems and answer questions relative to the medical aspects of school sports.

In response to Resolution #19 passed by the House of Delegates at the 1976 annual meeting, the Commissioner of the State Department of Education was advised of the Society's develop-

ment of an advisory committee of physicians knowledgeable in health, education, and nutrition. A response indicated the establishment of a liaison representative who would interact with the Society's committee, with particular emphasis on health and nutritional programs for New Jersey Schools.

Other activities of the Committee included recommending to the Assistant Commissioner of the State Department of Health, Dr. Martin Goldfield, that the perinatal screening programs for hypothyroidism be undertaken and also, that serious consideration be given for screening for other inborn areas of metabolism that currently are remediable by dietary management, particularly galactosemia and maple syrup urine disease. The other area of activity is the participation of one of the Committee members on the advisory council of the Department of Education.

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## Conservation of Hearing and Speech

**Aris M. Sophocles, M.D., Chairman, Trenton**

(Reference Committee "G")

In its first year as a separate committee following approval by the Delegates of The Medical Society of New Jersey at the Annual Meeting in 1976, the Committee has met on two occasions, showing enthusiasm and vigor. The members of the Committee are primarily otolaryngologists, in most cases heavily involved with otology, with one member especially active in the fields of plastic surgery as well as general otolaryngology and ophthalmology. Our objective is to make the best possible contribution to the field of communication.

Our limitations in the field of speech pathology, and thereby conservation of speech, became apparent and guest lecturers and new members for the Committee have been sought in order to broaden the expertise of committee members.

The Committee again has tackled the project of screening of hearing in the public school systems as presented to the New Jersey Senate in bill S-851 and introduced by Senator McGahn. Some contacts have been made; however up to this point there is no evidence of momentum

in its progress toward becoming a reality.

The Committee is also interested in the matter of presenting a scientific exhibit at the 1977 Annual Meeting and the cooperation of representatives of the local chapter of the American Speech and Hearing Association has been obtained. It is indeed a pleasure to have the assistance of these devoted professionals in the preparation of an exhibit depicting the various activities through which conservation of hearing and speech can be accomplished.

### Recommendations

1. We ask that every physician, and especially those involved in school health, insist that the local schools carry out annual screening of hearing; and

Approved (page Tr 139)

2. That speech pathologists be included in all school special services teams for the improvement of the child's ability to communicate.

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## Conservation of Vision

Alfonse A. Cinotti, M.D., Chairman, Jersey City  
(Reference Committee "G")

The 20th Annual Eye Health Screening Program was held during the week of September 12, 1976. A total of 93 hospital centers participated in the program. The number of patients screened was 10,949, of which 5,099 had a positive test finding. The testing included visual impairment, ophthalmoscopy, external conditions, and tonometry.

Of those screened, 589 had positive tonometry tests. A follow-up of these cases by the New Jersey State Commission for the Blind and Visually Impaired reveals that 131 of the 589

tonometry-positives were diagnosed as having glaucoma; 29 cases were borderline; and 213 were negative. The Commission, in addition to letters, phone calls, and home visits, is still attempting to follow-up the remaining 216 cases.

Since its inception, this program has screened 188,018 patients, of which approximately 1,400 patients with glaucoma have been found, as well as numerous other conditions.

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## Environmental Health

Richard H. Musgnug, M.D., Chairman, Cherry Hill  
(Reference Committee "G")

The Committee met at the 1976 Annual Meeting in Cherry Hill to consider supporting a resolution before the House of Delegates calling for a moratorium on the building of nuclear power plants in our State. The resolution was dis-

cussed by the Committee members and our invited guest, Dr. Salasin, Chairman of the Council on Public Health, and we voted unanimously to support the resolution in whatever way possible.



We also discussed the problems of air and water pollution and the State rating as the number one state in the country for the incidence of cancer. In an attempt to develop a line of communication with the agencies within the State who should be most directly concerned with this rating and its implication, we arranged a joint meeting with members of the Environmental Protection Agency and the New Jersey State Department of Health.

At this meeting we met with Glenn Paulsen and Peter Preuss from the EPA and Mr. Zanna from the Department of Health. Dr. Paulsen distributed copies of the Agency's report to the Governor dated May, 1976 entitled "Cancer and the Environment" and a memo regarding the Agency's Environmental Protection Cancer Program. It was pointed out that the Governor's Cabinet Committee on Cancer Control is seeking additional funding for a more comprehensive program in this area.

Suggestions were made to both Departments that the Medical Society would appreciate closer lines of communication with these agencies so that we could be part of the decision-

making process. For example, one of the recommendations of the Governor's Blue Ribbon Cabinet Committee was to develop a cancer-incidence registry in the State. We pointed out to Dr. Paulsen that there are currently 45 cancer registries operating in New Jersey hospitals.

We also suggested that The Medical Society of New Jersey could be informed better regarding their activities if these agencies would consider publishing some of their pertinent reports regarding environmental health, cancer programs, and others in *The Journal*, MSNJ.

At various times during the year Dr. Seymour Charles has represented us by giving testimony before the Clean Air Council. Both Dr. Charles and Dr. Musgnug have been appointed to the Ad Hoc Committee studying the problems of nuclear power plants in the State.

We have also asked the EPA to keep us posted on their toxic substances, program and the problem of sludge dumping off the Jersey coast.

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## Maternal and Infant Welfare

Edward Foord, M.D., Chairman, Burlington

(Reference Committee "G")

The Committee met on November 21, 1976 and completed a detailed review of the remaining cases for 1975. It was the consensus of the Committee that the majority of cases were non-preventable, however, approximately thirty percent had received little or no prenatal care. In a few cases regarded as possibly preventable, there were socio-economic factors involved pointing to patient responsibility. The Committee emphasized that while many patients of either category had received little or no prenatal care, once hospitalized, they received very good obstetrical care. The basic problem is

all too frequently one of patient motivation to accept prenatal care available at various hospital-based and satellite clinics.

The educational value of this review is presently available only to members of the Committee, and while published abstracts surely would be of clear benefit to the profession, the hovering sword of professional liability hangs much too heavily to allow dissemination of useful review. It is nonetheless clear that, while maternal death from post-abortal sepsis has been greatly reduced, toxemia, hemorrhage and embolic

episodes are still the leading causes of death. Such entities clearly require *early prenatal care*, progressively more complex methods of diagnosis, and detailed follow-up, if prevention is to be achieved.

In addition, the Committee considered guidelines for prenatal screening and a proposed review of the maternity service record books.

The future scope of this Committee as it relates to many expanded and detailed activities of maternal and child care was introduced by Dr. Felix Vann.

These last three items will be considered at future meetings.

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## Administrative Council

### Public Relations

John P. Kengeter, M.D., Chairman, Toms River  
(Reference Committee "E")

The Council on Public Relations has continued its policy of adaptation to the needs of The Medical Society of New Jersey's membership and the urgencies of the times.

#### 1. Continuing projects:

##### a. Publication and distribution of:

- (1) *Membership Newsletter*.
- (2) *Periodic Newsletter* to cooperating agencies/individuals as required.
- (3) Monthly news media releases on public health and professional liability (statewide newspapers and TV).

##### b. Preparation and publication of special news releases and publicity as required from time to time, in furtherance of the Society's business, interests, and activities, including:

- (1) The Eye Health Screening Program.
- (2) The Annual Meeting, to include the Governor's Conference.
- (3) Child Safety Week.
- (4) Selected official programs and activities.
- (5) Professional Liability—statewide newspaper releases explaining the MSNJ position on Professional Liability and the problems that are being reflected on patient care, and will continue to be incurred unless some relief is granted in the form of proper legislation. MSNJ is also preparing TV spot releases to carry the proper message to the public requesting their understanding and help in procuring fair and equal legislation to serve the best interests of all concerned.
- (6) Legislative Meetings—meetings were arranged between individual key legislators and MSNJ representatives in order to explain the need for proper professional liability legislation and to present the medical side of this problem. These meetings also were used to open rapport and estab-

lish better communications with the legislators.

(7) Reestablishment and updating of a legislative keyman system for legislative public relation activities.

(8) JEMPAC—cooperation with JEMPAC Committee in the preparation and the dissemination of new promotional material, including surveys and artwork for their new logo.

c. Responsibility for the information center and issuance of press releases at the Annual Meeting.

d. Responsibility for bestowal of the Golden Merit Award: 59 were bestowed in 1976, 27 in person, making a total of 940 since the award's inception in 1957.

e. Encouragement of continuance—or establishment—of orientation programs for new members under the sponsorship of component societies.

f. Encouragement of statewide emergency medical care coverage, particularly with reference to the "Basic Concepts Underlying the Provision of Professional Medical Care" as adopted by the House of Delegates and printed in the "Appendix Reference Information" of the *Membership Directory*.

g. Encouragement of increased voluntary blood donations.

h. Encouragement of radio broadcasts under the auspices of component medical societies. Plans have also been made to originate broadcasts at the Annual Meeting.

i. Encouragement of medical TV programs.

j. Diabetes Detection Week.

k. Placement service in *The Journal*. If possible, a booth also will be staffed at the Annual Meeting.

l. Physicians Awards for Community Services:

- (1) A. H. Robins Award
- (2) Sheen Award

2. It was agreed to work closely with the Council on Legislation to insure total coverage for major Medical Society legislative activities. Several specific recommendations were made:

- a. That the keyman system be revised using a survey of the membership to determine areas of influence.
- b. That JEMPAC activities be encouraged and its efforts given wide distribution.
- c. That the county societies participate more effectively in personal contact with State legislators.

3. A major thrust on professional liability is to be assumed, with the first four months of public relations promotion in 1977 being in this area. The information to the public regarding various elements of the problem, such as the need for public support of our legislative efforts and the effect of higher premiums (among other factors) on health costs has been augmented by the firm of Paolin and Sweeney. This advertising firm prepared newspaper advertisements that were released on a monthly basis. (This firm also has prepared posters on standard health matters for office use and television commercials.)

4. It was agreed that all advertising, whether free or paid, should aim at:

- a. Improvement of our public image.

- b. Increasing physician participation in MSNJ activities.
- c. Improving the attendance at the MSNJ convention.

5. Liaison was effected with the Committee on Medicaid and will be maintained.

6. The following is recommended to all our membership as incorporating the most effective methods for good public relations:

- a. Please read the literature distributed including the *Newsletter*, *The Journal*, and special releases. This would do most to relieve the so-called "communications gap."
- b. The county officers and secretaries should inform their membership of information contained in the minutes and other releases sent them.
- c. More of the membership should participate—at all levels, and in particular in the political scene.
- d. Attendance of the presidents and presidents-elect at meetings should improve.
- e. Trustees should be invited to meetings of the county societies.
- f. Consideration should be given to county meetings with their local press representatives and with their local legislators.
- g. The best public relations is on a one-to-one basis, not only with the press and with legislators, but most especially with patients—in the best tradition of medicine.

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## *Special Committees*

### **Chronically Ill and Aging**

**David Eckstein, M.D., Chairman, Trenton**  
(Reference Committee "G")

The Committee has had no formal meeting this year and thus has no formal report to make to the House.  
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### **Emergency Medical Care**

**Jack R. Karel, M.D., Chairman, Hillside**  
(Reference Committee "D")

With the increasing importance of emergency departments in hospitals and their constant exposure to the public, a situation has been presented that necessitates constant vigilance on the part of emergency personnel to give the best emergency care possible. Professional liability considerations are a major problem that demand the utmost attention. It is thus obvious that the cost of emergency medical care in emergency departments will increase if physicians and hospitals are to maintain optimum care to the public. The Special Committee on EMC has remained active in this field in various areas.

#### **CARDIO-PULMONARY CERTIFICATION**

The Board of Trustees approved the recommendation that additional organizations must be involved in this program if adequate numbers of individuals are to be trained in Basic CPR and as instructors. The following organizations have been approved to accomplish the above training: American Heart Association, New Jersey Chapter; American Red Cross; American College of Emergency Physicians, New Jersey Chapter; New Jersey College of Medicine and Dentistry, and the Emergency Department Nurses' Association, New Jersey Chapter. The latter organization will work closely with ACEP in this training. Basic and instructor classes are now underway.

#### **CPR CERTIFICATION OF LIFEGUARDS**

Our committee has recommended that all lifeguards in the State of New Jersey be trained in Basic CPR and certified upon their employment. These individuals can obtain this training from any of the above agencies. Notification of this recommendation is to be made to the New Jersey State Department of Health and the Boards of Chosen Freeholders.

#### **BURN VICTIMS**

In order to upgrade statistical information on the frequency, type, and treatment of all kinds of burns, the committee has maintained contact with the National Burn Victim Foundation in New Jersey. Recommendation was made by the committee that all hospitals with emergency departments utilize a special form for the information requested when a burn victim appears in the hospital. This recommendation was forwarded to the New Jersey Hospital Association and the National Burn Victim Foundation, which in turn forwarded a large quantity of these burn forms to all hospitals. It is important that hospital emergency departments complete these forms expeditiously and forward them to the National Burn Victim Foundation since a survey of the entire state on this program is urgently needed. This information will also be of great value for obtaining federal

grant support under Public Law 94-573, 94th Congress, Emergency Medical Services Amendments of 1976.

#### NATIONAL HEALTH PLANNING AND RESOURCE DEVELOPMENT ACT OF 1974

We are maintaining close observation of this legislation and have noted unusual delays and contradictions in its development. To this end, we have been in constant communication with our congressional representatives.

#### INTER-AGENCY COMMISSION ON EMERGENCY MEDICAL CARE

Work continues in various aspects of EMC. The Commission is represented in the State Mobile Intensive Care Program as well as in the New Jersey Emergency Medical Services System Council by several members of the Commission.

#### TRAINING

A Seminar on EMC for Physicians and Nurses will be held in 10 hospitals throughout the state starting in April and to be completed in June 1977. Cooperating hospitals are: Dover General Hospital, St. Joseph Hospital and Medical Center, Cooper Medical Center, Monmouth Medical Center, Middlesex General Hospital, St. Elizabeth Hospital, Elizabeth General Hospital, Jersey Shore Medical Center, Saint Francis Hospital and Medical Center and The Mountainside Hospital.

#### MEDICOLEGAL SEMINAR

A Medicolegal Seminar entitled "Avoiding Pitfalls in EMC" was held in December 1976 at which time a highly successful trial demonstration was held. This seminar was a follow-up to a previous one on the pitfalls in EMC. The latter received national attention and our booklet was abstracted in the *American Journal of*

*Law and Medicine.*

#### EMERGENCY DEPARTMENT NURSE TRAINING PROGRAM

The Commission, in cooperation with the New Jersey Chapter, Emergency Department Nurses Association, will submit an application to the USPHS, DHEW for a federal grant to conduct a five-week training program for emergency department nurses. Four weeks will cover the didactic and practical instruction and the fifth week will be in-service work in hospital emergency departments. Hospitals throughout the state have been surveyed and the endorsements indicate that this program will be oversubscribed. This project will take two years for completion for approximately 300 students. The course would be conducted in three schools of nursing. The curriculum for this project was developed by the Commission's Committee on Training and 14 nurses and based on an outline for such training and funded under a federal contract.

#### A PLAN FOR MASS CASUALTY CARE (NON-NUCLEAR)

Based upon the initiative of the Commission and the Special Committee on EMC and having been informed by the State Office of Civil Defense and Disaster Control that there was no plan in New Jersey for the care of mass casualties (non-nuclear), meetings are now being held to accomplish this goal with representatives from MSNJ, New Jersey Hospital Association, New Jersey State First Aid Council and the State Office of Civil Defense and Disaster Control. Resources documented in our Commission's Plan completed in 1976 will be utilized. A Mass Casualty Care Plan is expected to be completed this year with an exercise projected for the Fall of 1977.

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# Long Range Planning and Development

William J. D'Elia, M.D., Chairman, Spring Lake

(Reference Committee "A")

The Committee met twice during the 1976-77 administrative year and will meet once more before the Annual Meeting.

## TENURE OF THE EXECUTIVE DIRECTOR

The Committee considered a referral from the Board of Trustees concerning the tenure of an individual serving as Executive Director of the Society. Considerable discussion centered around whether or not definitive parameters on the tenure of the Executive Director should be established by either adoption of a Bylaw amendment or a position statement.

The Executive Director recommended that the tenure of any person as Executive Director (Chief Executive Officer) of the Society should be limited to fifteen years.

Supportive reasons for the above include, but were not limited to, the following:

(a) Such a policy would be sound corporate management and assures the Society of the infusion of new talent, vigor, and enthusiasm at the top management level on a predictable and routine basis.

(b) The office in question involves a certain fiduciary obligation actively to prod the organization to adapt to a constantly changing environment. Repetitive failure would produce apathy and dampen enthusiasm. Repetitive success could form a base of power which could become subject to abuse. Limited tenure would circumscribe the detrimental possibilities of such events.

(c) The terms of officers and trustees are currently limited, while that of the Executive Director is not. The maximum tenure of any person as a trustee and presidential officer under current and proposed policy would be fourteen years. Limiting the Executive Director to fifteen years assures continuity but at the same

time grants conformity across the spectrum. Further, it allows sufficient time to accrue respectable pension benefits but would reduce pension expenditures and salary demands to a manageable level for MSNJ.

The Chairman of the Board of Trustees regularly attends meetings of this Committee and was present when this item was discussed. He pointed out to the Committee that the Executive Director and his executive staff are under a three-year contract with the Society. At the time of the contract renewal, each member of the executive staff is evaluated in accordance with the duties outlined in their job descriptions. Therefore, if the Society is not satisfied with the accomplishments of any of these individuals, it always has the option of not renewing their contracts.

The Committee therefore voted that no change be made in the current policy of the Society. The Board of Trustees subsequently approved the Committee's recommendation.

## AD HOC COMMITTEES

At the suggestion of the Committee, the Board of Trustees approved a recommendation which now gives the chairmen of the Society's councils and committees the authority to appoint consultants to serve on their councils and committees whenever the chairman feels that his council or committee lacks specific expertise in those areas which cannot be carried out properly within the structure of the current membership.

## MEDICAL DIRECTOR FOR MSNJ

At its meeting on October 17, 1976, the Board of Trustees considered the September 16, 1976, report of the Ad Hoc Committee to Study a Medical Directorship for MSNJ. Within the Ad Hoc Committee's report was a list of strategies recommended in lieu of employing a Medical Director for the Society. These recommenda-



tions were referred to the Committee on Long Range Planning and Development, in consultation with the Executive Committee, for consideration and report back to the Board. The joint suggestions of these two Committees follow:

1. That candidates for presidential offices should be selected primarily on the basis of ability and competence.

Obviously, no one can take issue with this concept. The new nominating procedure should encourage a more responsive election process. In addition, candidates should be requested to author position papers in Society publications and be available to speak at various county society meetings.

The Board of Trustees concurred with this opinion.

2. That some reorganization and delineation of the duties of the present presidential officers should be considered.

3. That all of the presidential officers should increase their activities in ceremonial and other delegated official business of the Society.

These items were considered together because of their relationship. They offer a sound approach for making the Society more viable and effective both internally and externally. These matters really should be implemented by the President and the Executive Committee as time passes. The Chairman of the Board should also be utilized in this expanded concept.

The Board of Trustees concurred with this opinion.

4. That the Special Committee on Long Range Planning and Development consider the recommendation of merging the duties of the Secretary of the Board of Trustees with those of the Secretary of the Society.

The consensus was that this is indeed desirable. The Committee recommended that the Standing Committee on Revision of Constitution and

Bylaws be directed to develop the appropriate Bylaw language.

The Board of Trustees approved the recommendation of the Committee.

5. That the President also serve as Chairman of the Board.

The consensus was that the pressure of Society business does indeed demand the vigor and talent of two people. The current system of an elected Chairman could, in future years, present some difficulty if the President and the Chairman are not compatible. The consensus was that the Bylaws should be amended to provide that the Chairman of the Board of Trustees shall be appointed by the President.

The Board of Trustees took the following actions with respect to this recommendation: (a) voted to retain the position of Chairman of the Board; (b) directed that the individual named Chairman of the Board should be appointed by the President, with the advice and consent of the Board of Trustees; and (c) directed that the Standing Committee on Revision of Constitution and Bylaws develop the appropriate Bylaw language.

6. That consideration be given to a Bylaw change to permit the President to succeed himself a second term.

The Committee believes this issue has merit and that the Committee on Revision of Constitution and Bylaws should give it careful study. It is not a pressing problem at this time, and it is unlikely that even if the post of President-Elect were abolished or remained vacant, that an incumbent President would be able to serve another term and maintain a viable practice.

The Board of Trustees voted to table the recommendation indefinitely.

7. That the President and the Executive Director should have the authority to commit the Society to a decision which may arise in an emergency.

The consensus was that there is no need for this format since the Executive Committee or a majority thereof could act just as quickly.

The Board concurred with this opinion.

8. That the Executive Committee be structured to include the Immediate Past-President.

The Committee recommended that the Standing Committee on Revision of Constitution and Bylaws be directed to develop the appropriate Bylaw language.

The Board approved the Committee's recommendation.

9. That the Executive Committee meet on a regular basis to discuss the responsibility and duties of the presidential officers.

This is a favorable concept which has been implemented for the past several years. The Committee did not believe any formal action was necessary.

The Board concurred with the opinion of the Committee.

10. That compensation for Presidential officers be reconsidered and made commensurate for the time and effort demanded.

Previously, in items 2 and 3, the Committee discussed expanding roles for these officers. The Society really cannot compensate its officers adequately for the services they render, but it can offset some of their lost income. It is not the Committee's intent to provide compensation for routine meeting attendance but only for expanded responsibilities and efforts. The basis should be a per diem set by the Committee on Finance and Budget. The Chairman of the Board also should be included in this concept.

The Board concurred with the opinion of the Executive Committee and directed that the matter of compensation be referred to the Standing Committee on Finance and Budget.

Filed (page Tr 129)

## Medicaid

**Harvey J. Shwed, M.D., Chairman, Newark**  
(Reference Committee "F")

The Medicaid Committee was formed as an ad hoc committee of the Medical Society in response to the emergent issues of Medicaid cutbacks in August 1975. The Committee has assumed ongoing responsibility. In the year since the last report it has functioned in the following way:

1. The full committee meets monthly at the Medical Society office for a dual purpose. One phase of the meeting is an Intra-Medicaid committee meeting with Society members, representatives of specialty groups and observers from other health care providers (e.g., Dental Association, Osteopathic Association, optome-

trists, pharmacists, and so on). The second part of the meeting is the liaison meeting with representatives of the New Jersey Medical Assistance Agency (Medicaid). These joint meetings have been productive in settling differences, bringing up issues related to rules and regulations in Medicaid, issues of confidentiality and consultation reports, fiscal issues, and so on.

2. The Committee has been very active in attempting to counter negative media publicity in relation to Medicaid and the physician.

a. Reply editorial on metropolitan NBC was aired in October 1976.

b. A letter to Mr. Arthur Sulzberger, publisher of *The New York Times* was given wide publicity and was reprinted on the editorial pages of the *American Medical News*.

c. The Committee members appeared at Governor Byrne's signing of increased Medicaid penalties. A press conference was held following the signing of the law and representatives of the Committee underscored the dangers of blanket media disapproval of the individual physician who sees Medicaid patients.

d. The Medicaid Committee has completed a rough draft of a "White Paper" which explains the private physician's position on Medicaid and the delivery of health care to the poor.

e. The Medicaid Committee, through the Essex County Medical Society, held a legislator-physician brunch in December 1976. The Committee hopes that this will serve as a model for

other county affairs between legislators and physicians concerning Medicaid.

f. The Committee functions as a funnel for physician complaints in relation to Medicaid regulations, rules, procedures, policy decisions, and so on. Most recently it has served as a stimulus for the creation of an ad hoc committee to study rules and regulations in regard to physicians caring for patients in nursing homes.

I would like to thank the members of the Committee who have faithfully and selflessly given of their time to work for the Committee. I especially would like to thank Dr. Seymour Charles, Dr. John Alexander, Dr. Arthur Maron, and Mr. Joseph Lucci and his secretarial staff for their help and devotion to a very difficult task.

**Filed (page Tr 137)**

## Medicine and Religion

**Thomas H. McGlade, M.D., Chairman, Camden**

(Reference Committee "D")

This Committee has not held meetings during the past year. An innovation during the Annual Meeting will be a Prayer Breakfast. The program will include readings from the Old and

New Testaments and a presentation of the Sanctity of Life. It is hoped that this will become an annual event.

**Filed (page Tr 135)**



# Membership Inquiries and Complaints

Joseph C. Lucci, Executive Assistant, Trenton  
(Reference Committee "F")

INQUIRIES AND COMPLAINTS  
APRIL 1, 1976 TO MARCH 9, 1977

## MEDICARE

This Committee did not meet formally, since all complaints were resolved to the satisfaction of the physicians. A total of eight complaints were received. One complaint is pending.

## MEDICAID

This Committee did not meet formally, since all complaints were resolved to the satisfaction of the physicians. A total of eight complaints were

received.

## MEDICAL-SURGICAL PLAN OF NEW JERSEY

This Committee did not meet formally since all complaints were resolved to the satisfaction of the physicians. Two complaints were received.

## OTHER HEALTH INSURANCE CARRIERS

This Committee did not meet formally since all complaints were resolved to the satisfaction of the physician. Two complaints were received.

Filed with notation (page Tr 137)

# Physicians' Relief Fund

Joseph J. Kline, M.D., Chairman, Trenton  
(Reference Committee "B")

The Committee had applications for financial assistance submitted during the last year. Only one such application was completed and considered to be a valid request within the Committee's jurisdiction and responsibility. The appropriateness and extent of the need was determined by your Committee. A total of six (6) monthly payments were granted.

Experience thus far demonstrates that both the county societies and individual members are not fully aware of the availability of financial assistance MSNJ can offer at times of great need. Your Committee accidentally and belatedly learned—after the fact in at least two instances—that members of the Society could and should have been helped in terminal and tragic conditions. Unfortunately, no one made application for such aid or informed your Committee of the situation.

Regular and prominently displayed notices of the existence of the Physicians' Relief Fund should be printed in the state and county publications. County societies could serve their membership more effectively by initiating immediate requests for aid to your Committee and by prompt response to the inquiries made by your Committee.

Your Committee would welcome any contribution to the Fund which would further financial support to our fellow members who may experience severe financial need.

The financial activities of the Fund during the year are included in the report of the Treasurer.

## Recommendations

(a) That the House of Delegates concur in the

recommendation of the Finance and Budget Committee—approving a budget appropriation of six thousand dollars in lieu of a special per capita assessment for 1977-78 in support of the Physicians' Relief Fund.

**Disapproved (page Tr 131)**

(b) That the MSNJ membership be urged to continue their active support by sending contributions to the Fund.

(c) That MSNJ and county society publications include prominently displayed notices of the existence of the Physicians' Relief Fund.

Note: The Committee on Finance and Budget reported no allocation for Committee on Physicians' Relief Fund for 1977-78 because an audit by IRS revealed Fund to be in violation of 501-(C)-(6) non-profit status MSNJ has held over the years.

**Filed (page Tr 131)**

## Retirement Plan for Physicians

Nicholas E. Marchione, M.D., Chairman, Vineland

(Reference Committee "C")

### HR-10 (KEOGH) VARIABLE ANNUITY RETIREMENT INVESTMENT PLAN

Our Keogh Plan provides tax-deductible contributions up to the lesser of \$7,500 or 15 percent of earned income. In addition, voluntary contributions of up to the lesser of \$2,500 or 10 percent of earned income may be made to take advantage of the tax-free compounding and favorable final funding guarantees. The Medical Society of New Jersey Retirement Plan Trust was modified accordingly and many members have taken advantage of this liberalization by increasing their contributions to the Plan.

The Plan was established in 1970, following the success of the identical Essex County and Union County Medical Society Retirement Plan Trusts. The program includes three unique advantages, in addition to the well-known tax saving and tax shelter features of the Keogh Law:

1. A lifetime monthly variable payout based on a common-stock portfolio. (The Variable Annuity)
2. A death benefit guarantee that if the participant dies during the accumulation period, his beneficiaries will never receive less than the amount the participant contributed.

3. Flexibility during accumulation years, permitting the allocation and transfer of funds, at your option, to and from the common-stock and the fixed-dollar account.

Internal Revenue Service approval for the Master Plan (with Serial Number 701115) was received November 30th, 1970.

Throughout the state, we have 186 plans in effect covering 208 people with \$1,646,899.27 deposited by members of the program, since its inception.

### CORPORATE MASTER RETIREMENT PLAN

The Society has recognized that some of its members may see fit to practice in the form of a corporation. Therefore, the Committee recommended, and the Society approved in 1970, the establishment of The Medical Society of New Jersey Retirement Plan Trust-B, which adopted a Corporate Master Retirement Plan, using the same funding agents as the Keogh program described above. This program, in the form of a Master Profit-Sharing Plan, permits corporations, one of whose employees is a member of the Society, to place up to 15 percent of payroll in a tax-sheltered program with the

same flexibility and options as our Keogh program, using the Prudential Insurance Company's group Fixed-Dollar Annuity and group Variable Annuity. Some of the useful and valuable features of this Master Plan are described below:

1. Eligibility Requirements—Employment 0 to 5 years—Minimum age up to 30
2. Flexible Retirement Date (especially valuable for older corporate officers)
3. Choice of contribution formulas, including *Social Security integration*
4. Vesting can be as minimal as nothing for the first five years under the plan and then 10 percent per year for the next ten years.

The plan is administered by E. & W. Blankstein Agency, Inc., who will be pleased to furnish members with full information. This plan should provide a substantial savings, since it is not necessary to have a plan and trust drawn especially for you. Many large corporations and other organizations use these same funding agents for their tax-deferred retirement plan, including that of our administrator.

#### PRO SERVICES, INC.

The Medical Society of New Jersey PRO Master Retirement programs provide members with pre-approved prototype plans for: IRA — Keogh — Corporations.

If you are currently participating in a tax qualified retirement plan, or if you contemplate establishing such a plan, you should consider the advantages which are available through The Medical Society of New Jersey Group Master Plans.

Some of the important features are as follows:

1. *Investment Options*—You may select any investment permitted under law—mutual funds, stocks, bonds, savings accounts, to mention a few.
2. *Unlimited Transfers*—If your original investment choice does not live up to expectations, you may switch investment options at any time with no charge.
3. *Segregated Accounts*—To avoid liability for you as an investment adviser, the Society plans permit each employee to select his or her own investments which are best suited to individual needs and temperaments.
4. *"In Kind" Transfers*—You may transfer the assets of your current plan (or plans, if you have more than one) over to the Medical Society plan without the need to liquidate your present satisfactory investments.
5. *Full Service*—Your society plan offers free assistance and necessary information to help you in reporting in compliance with the new pension law.
6. *Bank Trustee*—These Master Retirement programs are fully trustee and you will receive accurate and understandable reports on a quarterly basis.
7. *Low Cost*—All the advantages of these plans are available to you at low group rates.
8. *Full ERISA Compliance Service*—PRO, as the service agent for the Society plans, will accept appointment as Administrator of your PBA Plan with full responsibility for ERISA compliance. Under an optional fee for service contract with an employer, PRO Administrators, Inc. will accept responsibility as the Employer's Plan Administrator for timely compliance with all ERISA requirements, as follows:
  - Plan Description
  - Summary Plan Description
  - Plan Amendments (when notified in writing by the Employer)
  - Annual Report
  - Annual Report Summary
  - Employee Benefit Statements (when notified in writing by the Employer of a request from an employee)
  - Write and distribute required reports to participants.

**Filed with commendation to the Chairman (page Tr 133)**



# Ad Hoc Committee on Atomic Energy Plants

Howard D. Slobodien, M.D., Chairman, Perth Amboy

(Reference Committee "G")

This Committee was founded as a result of Resolution #40, which was adopted, as amended, by the 1976 House of Delegates as follows:

## ATOMIC ENERGY PLANTS

RESOLVED, that The Medical Society of New Jersey vigorously support

1. further study of the health implications of an atomic energy plant off the coast of New Jersey.

2. a committee of selected physicians, appointed (by the Board of Trustees) for the urgent task of meeting with the scientists of the appropriate nuclear energy commission as soon as possible, whose findings shall be reported to the 1977 House of Delegates of The Medical Society of New Jersey.

This Committee, after review of resolution #40, agreed that limiting its studies to atomic energy plants off the coast of New Jersey would not be advisable, since construction and utilization of the plants anywhere in the State could have an effect on the health and well-being of the people. At the request of the Chairman of the Committee, the Board of Trustees authorized the Committee to expand its purview to include investigation of the original resolution that was presented to the House of Delegates prior to amendment by the Reference Committee.

The specific issues the Committee addressed included the following:

1. Transportation of radioactive materials—this will include transportation of materials to be used as fuel, as well as waste products;

2. Local storage of fuel and waste materials—how and where;

3. Operational plant safety—dangers to the community with regard to radioactive core melt-down, and dangers to the employees in the general daily plant operations;

4. Environmental impact—comparison of conventional coal-operating plants to a nuclear-powered plant. The Committee decided that, since the use of oil as a fuel will, for all practical purposes, soon be phased out, study was not necessary on its long-term effects on the environment;

5. Locations for nuclear sites—underground, off shore, and above ground;

6. Better understanding of what the actual hazards of radiation exposure to the human body are—degree of dosage and long-term exposure;

7. Evaluation of guidelines to be followed in the event of an emergency occurring at the power plant—notification to the public, evacuation, and medical care.

All were in agreement that a statement on nuclear power plants could not be made by this Committee solely from review of the written materials available. Experts, both for and against the development of nuclear power plants, were consulted and a full day spent with them. These were the consultants:

Dr. Edward P. Radford, Professor of Environmental Medicine, Johns Hopkins University.

Dr. Charles Huver, Biologist on Environmental Quality, University of Minnesota.

Dr. Roger Linnemann, Radiologist and President of Radiation Management Corporation, Philadelphia.

Mr. Andrew P. Hull, Section Leader on Environmental & Analytical Services, Brookhaven.

Mr. Robert Casey, Operational Health, Physics and Safety Section, Brookhaven.

A follow-up letter was received from Dr. Radford. In this letter he called for a review of current occupational radiation exposure standards at power stations in New Jersey and said he had some innovative ideas regarding this. We await this information.

After extended discussion the following were established as the majority positions of this

Committee regarding atomic energy plants in the State of New Jersey; each numbered item refers to the specific issues agreed to previously:

1. According to expert testimony, there is no evident hazard in the transportation of radioactive materials currently being used and transported in the State of New Jersey. The containers used are designed for maximum safety so that even in an accident involving the transporting vehicle, no radioactive material is released.

2. The temporary storage of radioactive fuel and waste materials should be on the site of the power plant. It should not seriously affect the amount of local radiation, and should not cause any hazards to local population if the current strict regulations of the Nuclear Regulatory Commission are followed. Sites for permanent storage must be developed.

3. Regarding operational plant safety for employees, the amount of radiation released into the local atmosphere is very small, much less than from other common sources, and poses no apparent threat if NRC guidelines are followed strictly. With regard to radioactive core melt-down, because safety regarding avoiding such an accident is still very controversial and there is considerable confusion among the scientific experts as to the possibility of such an accident, this Committee has been unable to make a recommendation on this particular problem. So far, the history of nuclear power plants with regard to melt downs has been good; but, because there are unknown factors and occasional leakage of coolant has occurred, a continuing effort must be made along these lines to establish better safety in this area.

4. The Committee decided that, since the use of oil as a fuel is for all practical purposes, of limited duration, study was not necessary on its long term effects on the environment. No critique could be given comparing coal to nuclear power because of time and statistical limitations.

5. Regarding off-shore nuclear power plants it was agreed that under normal weather con-

ditions an off-shore plant probably would represent no further hazard to core melt-down and leaks than on land and might offer some advantages in regard to the readily accessible sea water for cooling purposes. Many of the Committee are concerned that the engineering built into this type of power plant might not be able to withstand all types of weather conditions; it was therefore recommended that experts in the engineering fields should answer questions about design of these power plants and their ability to withstand all weather conditions, no matter how severe. In this regard, concern was also expressed about the potential amount of water-borne spread of radiation contamination and the problems arising should evacuation of populations on or near the beaches be needed.

It should be noted that Mr. Jonathan Law, one of our consultants, felt that sufficient engineering has been applied to forestall any possible weather condition. He referred to an article published in *The New York Times*, written by Ralph E. Lapp.

6. The radiation released into the local atmosphere, if any, from nuclear power plants is apparently much less than from other common sources and poses no apparent threat to area population as long as current strict NRC regulations are followed. Proper security measures are also essential and should be improved.

7. For guidelines to be followed in the event of an emergency occurring at a power plant, Roger Linnemann, M.D., Radiation Management Corporation, Philadelphia, Pennsylvania, should be contacted. Another source of guidelines is *Emergency Planning for Nuclear Power Plants*, Regulatory Guide 1.101 by the Office of Standards Development, U.S. Nuclear Regulatory Commission. This information should be made available to all hospitals in the state.

Certain other matters could not be resolved by the Committee because of a wide separation of opinions. The statement had been made by President Carter that nuclear power plants not

be located in populous areas. Whether this means all of New Jersey, the most populous state, is open to question. And we do know that losses of power in transmission lines are severe enough to warrant putting power plants near their areas of consumption of power. We are unable to resolve all the questions relating to the biologic effects of radiation; even the experts differ in opinion as to effect, whether it occurs

along a straight line or along a sigmoid curve. This latter dilemma relates to other situations also, such as occurred (and is still occurring) with the mammography controversy. But, if this type of question had an easy answer, there would have been no call for the formation of this Committee.

Filed (page Tr 140)

## Minority Report

Seymour Charles, M.D., Irvington  
Philip J. G. Quigley, M.D., Elizabeth  
(Reference Committee "G")

It is the conclusion of this minority that:

1. Atomic energy plant operational safety in New Jersey has not been assured.
2. Atomic energy plant site protection (security) in New Jersey has not been assured.
3. The safety of transportation in New Jersey of radioactive material to and from atomic energy plants is questionable.
4. The operational safety of the proposed floating ocean atomic energy plant off the New Jersey coast is not assured, and its protection

(security) is not assured, and its protection against weather hazards is not assured.

5. A burden of proof of safety of atomic energy plants in New Jersey is on the proponents and builders and operators thereof.
6. The Committee on Environmental Health of The Medical Society of New Jersey should be charged with the continuing review of these problems and the formulation of appropriate recommendations.

Filed (page Tr 140)



# Medical-Surgical Plan of New Jersey

Joseph P. Donnelly, M.D., President, Newark

(Reference Committee "C")

## MEETING TODAY'S CHANGING NEEDS WITH YESTERDAY'S UNCHANGING PRINCIPLES

"We must adjust to changing times and still hold to unchanging principles."\* Those words clearly express the continuing creed of Blue Shield of New Jersey, which was founded in 1942, with the approval of The Medical Society of New Jersey, with the objective: "To make available to every man, woman, and child in New Jersey adequate personal and sympathetic medical care, preventive and curative, at the lowest cost compatible with efficient service."

During 1976, our board of trustees reexamined Blue Shield's objective. It concluded that the goal still held. The principal considerations to achieve this end remain: service benefits, service, and effective cost-control measures. We haven't forgotten the reason for our founding. On the other hand we realize that, to continue serving our subscribers effectively, we must meet the challenges of changing times. Later in this report we will describe our major efforts in this direction.

## PAID-IN-FULL "SERVICE BENEFITS" CONCEPT CONTINUES

Service benefits continue as a humanistic endeavor provided by participating physicians to low income fixed-fee, and UCR (Usual, Customary or Reasonable Fee) subscribers. And, during 1976, we achieved the highest physician participation in our history. Some 10,000 physicians throughout the state have agreed to accept Blue Shield's payment for eligible services as payment in full when subscriber incomes are below specified levels in the fixed-fee programs, and some 8,800 physicians have agreed to provide service benefits to subscribers in the UCR program which has no income limits. The service benefits' program also continues as a principal cost containment measure, essential in this era of rapidly rising health care costs.

During 1976, in cooperation with the State Department of Insurance, Blue Shield launched

an intensive public relations and advertising campaign to educate subscribers of the availability of service benefits. It also undertook a study to evaluate the effectiveness of the service benefits' program and to determine the average "discount" made available through the service benefits' program.

## SAVINGS SEEN

It was found that subscribers whose incomes were below the eligibility limits of the Series 500 Fee Program saved an average \$53.75 per service in the 50 most-frequently-performed services, when having care rendered by participating physicians. Subscribers in the Series 750 Fee Program achieved a "discount" of \$26.25 for the same services through the cooperation of participating physicians, when incomes were below specified levels. In other words, participating physicians rendered covered care to low income subscribers in the Series 500 Fee Program at a 45.6 percent discount and at a 22.3 percent discount to those in the Series 750 program who were under the income limits of that program. Participating physicians received their usual, customary or reasonable fees for performing eligible services for UCR subscribers, and those subscribers also had no balance bills to pay.

The service benefits' concept is still viable today.

In order to make it easier for subscribers to determine which physicians had agreed to provide paid-in-full benefits, an expanded directory was developed which described the service benefits' program and listed participating physicians in all fee programs in each county. In early 1977 these new pamphlets were mailed to every public library in the state and to all groups of subscribers.

## BRINGING SERVICE CLOSER TO SUBSCRIBERS AND PHYSICIANS

In an effort to provide improved service to subscribers and physicians, new branch offices

\*Miss Julia Coleman, Teacher of President Carter

were opened in Paramus and Basking Ridge. The Basking Ridge office replaced the Morristown branch and Paramus, a new location, was designed to bring available resources closer to subscribers and physicians in Bergen and Passaic Counties. This brings the number of service offices to five. Our headquarters and principal service office remain in Newark. Other service installations are in Cherry Hill and Princeton.

#### CONTAINING COSTS A MAJOR CONCERN

Conservation of subscriber funds continues as a major concern. The Utilization Review Department which has a mission of recognizing, preventing, and eliminating misuse of Blue Shield benefits, had the most effective year in its history in terms of monies refunded and in prepayment savings, resulting in increased value of the subscriber health care dollar. Refunds from providers, savings as a result of prepayment review and changes in providers' patterns of billing, totaled more than \$2,200,000, an increase of almost \$947,000 over 1975 savings.

Activities of the Utilization Review Department included review of laboratory and x-ray services, hospital audits, visits to physicians where cases of misunderstanding and possible overuse of benefits were clarified, and distribution of educational posters.

Cost savings in Coordination of Benefits, Workmen's Compensation, No-fault Auto Insurance, and the UCR programs totaled more than \$10 million in 1976.

#### RETURN ON THE PREMIUM DOLLAR REMAINS HIGH

Maintaining its record among the highest of Blue Shield plans in return on the dollar in benefits to subscribers, Blue Shield of New Jersey in 1976 returned 89 cents of every dollar to subscribers in the form of benefits, retaining only 11 cents for operating costs. When you consider that more than 12,000 providers generated 3,142,000 claims during the year, this return on the dollar was an enviable record and one which cannot be matched by commercial companies. And our cost per

contract per month, at 93 cents, continued among the lowest in the nation.

#### HOPE FOR SAVINGS FROM NEW PROGRAM

In cooperation with the State Department of Insurance, we developed an Elective Surgery Second Opinion Program which we call ESSOP. Designed to help determine whether surgery is needed, and whether subscriber funds can be saved, the program was to become effective March 1, 1977 for some eight groups with a total membership of 600,000.

#### RECORDS SET

With a 34-year growth of from 4,000 members to about 4,000,000, Blue Shield serves more than half the population of New Jersey. In 1976, it paid a record number of claims for a record amount, \$150 million. Continuing efforts to improve the length of time between receipt and payment of claims resulted in 61 percent of claims being paid within 10 calendar days, 75 percent within 14 days, and 96 percent within 25 days.

#### SMALL RATE INCREASE GRANTED

Blue Shield sought a 31.2 percent rate increase in 1976 and was awarded a 9.85 percent increase effective in August. Its effect, therefore, was felt principally in the last quarter of the year. However, it was not sufficient to prevent the plan from going into a deficit position at year-end 1976, when the deficit stood at \$3,100,000. The rates were for a one-year period necessitating planning for the possibility of a rate request in 1977.

#### MEMBERS MOVE TO BETTER-PAYMENT PROGRAMS

Our goal of moving subscribers away from the old Series 500 Program and into the better-payment Series 750 and UCR Programs was largely achieved during the year.

Several years ago Blue Shield realized that because of inflation only a small percentage of subscribers was eligible for service benefits under the Series 500 fixed fee program. It then

developed the Series 750 program with higher income limits and better payments. By year-end 1975, half the subscribers had converted, and by year-end 1976 some two-thirds of our members were enrolled in the better programs.

PHYSICIAN RELATIONS DEVELOPS NEW SYSTEM

A new Physicians' Address File System was implemented in mid-1976, providing for the instantaneous update of address file records. This significantly improved our service to physicians and subscribers. The Physician Relations section answered more than 81,000 written inquiries during the year and responded to more than 130,000 telephone calls from providers seeking information or requesting supplies. Field activities included visits to doctors' offices, conferences at hospitals, and educational seminars for medical assistants.

PHYSICIANS' OFFICE MANUAL DISTRIBUTED

A new Blue Shield Office Manual for physicians greatly enhanced professional relations educational activities and was well received by the physicians and their office assistants. The manual enabled improved service to subscribers. It includes sections on how to complete a claim

form, benefit programs, complementary coverage, special Blue Shield programs such as FEP (Federal Employees Health Benefits' Program), payment notifications, service, and general information as well as a space for updates, which are new actions sent periodically to physicians on a special update letterhead.

FEE SCHEDULE REVIEWS

During the year studies of the Rider J laboratory fee schedule were commenced. These studies included modernization of terminology and content as well as updating of fees. New procedures were added to the surgical fee schedule. Development of a pilot program with the Union County Medical Society was begun for payment of consultation in doctors' offices in connection with the Pre-Admission Testing Program (PAT).

LOOKING TO THE FUTURE

Looking into 1977, we see thoughtful consideration of new programs or benefits for subscribers, and we see ourselves adjusting to changing times, yet adhering to unchanging principles.

Filed (page Tr 133)

COMPARATIVE BALANCE SHEET DECEMBER 31, 1976

<i>Assets</i>	<i>1976</i>	<i>1975</i>
Cash in Banks and on Hand	\$ 332,212	\$ 2,926,146
Investments	21,672,924	21,560,924
Accounts Receivable		
Subscriber Premiums	5,525,212	3,635,000
National Account Program	8,673,490	7,886,870
Federal Employee Program	2,454,895	2,523,377
Other	684,191	369,264
Accrued Income on Investments	304,920	366,008
Total Assets	<u>\$39,647,844</u>	<u>\$39,267,589</u>
<i>Liabilities</i>		
Provision for Medical and Surgical Claims	\$29,659,000	\$29,732,000
Unearned Subscription Income	6,501,000	6,031,995
Accounts Payable	1,892,251	2,012,609
Reserve for Group Contract Settlement	2,233,781	546,418
Deposits from Organizations	2,455,918	2,131,352
Total Liabilities	<u>\$42,741,950</u>	<u>\$40,454,374</u>
<i>Reserves for Protection of Subscribers</i>		
Unassigned	\$ (3,094,106)	\$ (1,186,785)
Total Reserves	\$ (3,094,106)	\$ (1,186,785)
Total Liabilities and Reserves	<u>\$39,647,844</u>	<u>\$39,267,589</u>



# COMPARATIVE STATEMENT OF OPERATIONS

	1976	1975
Subscriptions Earned	\$162,889,730	\$143,934,753
Less:		
Claims Incurred	\$147,767,483	\$138,286,109
Operating Expenses	<u>19,223,506</u>	<u>17,851,865</u>
	<u>166,990,989</u>	<u>156,137,974</u>
Loss from Underwriting Operations	(4,101,259)	(12,203,221)
Income on Investments	<u>1,378,706</u>	<u>1,546,083</u>
Operating Loss for the Year	<u>\$ (2,722,553)</u>	<u>\$ (10,657,138)</u>

# STATEMENT OF RESERVES FOR PROTECTION OF SUBSCRIBERS

	1976	1975
Reserves at Beginning of Year	\$ (1,186,785)	\$ 9,084,456
Operating Loss for the Year	<u>(2,722,553)</u>	<u>(10,657,138)</u>
	(3,909,338)	(1,572,682)
Reserves Adjustment:		
Non-Admitted Assets	\$ 653,206	\$ 18,935
Unrealized Capital	177,253	406,415
Miscellaneous	<u>(15,227)</u>	<u>(39,453)</u>
	<u>815,232</u>	<u>385,897</u>
Reserves at End of Year	<u>\$ (3,094,106)</u>	<u>\$ (1,186,785)</u>

TABLE 1  
ALL UNDERWRITTEN SERVICES & PLAN PAYMENTS— 1976

Type	# Services	%	\$ Plan Payment	%	Plan Pay / Service
Surgical	942,422	30.0%	\$ 71,353,238	48.2%	\$ 75.71
Medical*	1,821,773	58.0	46,893,916	31.7	25.74
Obstetrical	47,305	1.5	12,291,302	8.3	259.83
Consultation	115,630	3.7	3,464,046	2.3	29.96
Anesthesia	<u>215,351</u>	<u>6.8</u>	<u>14,025,648</u>	<u>9.5</u>	<u>65.13</u>
Total	3,142,481	100.0%	\$148,028,150	100.0%	\$ 47.11

The incidence rate for 1976 is 491 cases per 1000 persons enrolled.

\*Includes lab, X-Ray, physical therapy, etc.

TABLE 2  
RIDER SERVICES AND PAYMENTS— 1976

Surgical	114,459	16.2%	\$ 2,414,816	22.9%	\$ 21.10
Medical	5,490	0.8	375,429	3.6	68.38
Diag. X-Ray	239,951	34.0	4,541,208	43.1	18.93
X-Ray Therapy	1,391	0.2	178,607	1.7	128.40
Physical Therapy	13,344	1.9	203,701	1.9	15.27
Pathology	<u>331,586</u>	<u>46.9</u>	<u>2,829,704</u>	<u>26.8</u>	<u>8.53</u>
Total	706,221	100.0%	\$ 10,543,465	100.0%	\$ 14.93

TABLE 3  
DISTRIBUTION OF EARNED SUBSCRIPTION INCOME

Earned Subscription Income	\$162,889,730	100.0%
Incurred Claims	147,767,483	90.7
Surgical		43.7
Medical		28.8
Obstetrical		7.5
Anesthesia		8.6
Consultation		2.1
Operating Expense	19,223,506	11.8
Underwriting Loss	(4,101,259)	(2.5)

N.J. Participating Physicians

	Basic Percent as of 12-31		U.C.R.* Percent as of 12-31	
	1976	1975	1976	1975
By County				
Atlantic	324	321	298	295
Bergen	949	894	828	779
Burlington	408	376	365	325
Camden	872	871	814	798
Cape May	89	88	73	72
Cumberland	187	172	176	155
Essex	1533	1587	1331	1340
Gloucester	193	181	185	170
Hudson	767	728	676	632
Hunterdon	70	74	63	66
Mercer	533	550	483	497
Middlesex	593	560	519	472
Monmouth	590	563	480	450
Morris	552	529	470	441
Ocean	227	217	187	188
Passaic	585	612	528	526
Salem	66	64	64	61
Somerset	217	220	184	185
Sussex	99	99	86	83
Union	767	758	631	621
Warren	85	77	81	73
Out of State	294	285	192	175
Total	10,000	9,826	8,714	8,404
By Specialty				
Anesthesiology	394	378	414	398
Dermatology	154	150	126	122
Internal Medicine	1673	1585	1538	1422
Neurosurgery	91	87	62	64
Obstetrics-Gynecology	829	807	741	713
Ophthalmology	296	288	274	266
Orthopedic Surgery	342	334	271	255
Otolaryngology	176	175	148	148
Pathology	181	176	139	130
Pediatrics	743	711	633	585
Physical Medicine	36	39	28	28
Plastic Surgery	48	44	37	31
Bio-analytical Laboratories	90	95	71	76
Proctology	20	18	22	20
Psychiatry & Neurology	550	524	495	458
Radiology	372	365	324	299
General Surgery	919	908	804	793
Thoracic Surgery	84	81	71	64
Urology	202	203	193	190
Podiatry	392	388	333	327
General Practice	2408	2470	1990	2015
Total	10,000	9,826	8,714	8,404

\*Usual, Customary or Reasonable Fee Program

## OFFICERS

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John S. Robinson, Executive Vice-President and Secretary-Treasurer

Jean R. Geiger  
Vice-President—  
Communications

Francis J. Novak, Vice-President—Operations  
W. John Gould, Vice-President—Corporate  
Planning and Finance

Charles L. Cunniff, M.D.  
Vice President—Medical Affairs  
and Medical Director

## BOARD OF TRUSTEES

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\*John J. McGuire, M.D. (1976)

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William Mortenson (1978)  
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John R. Nevin (1979)  
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Sidney I. Simon, Ph.D. (1978)  
Morgan Sweeney (1978)  
Charles O. Tyler, M.D. (1977)  
Robert E. Verdon, M.D. (1978)

\*Deceased May 4, 1976

## TRUSTEES EMERITUS

	<i>Appointed</i>	<i>Term as Board Member</i>
Joseph I. Echikson, M.D.	1970	1954-1970
Elton W. Lance, M.D.	1971	1962-1971
John S. Thompson	1966	1942-1965
Thomas J. White, M.D.	1973	1951-1973
Joseph M. Keating, M.D.	1975	1953-1975

## ADVISORS TO THE BOARD OF TRUSTEES

	<i>Appointed</i>	<i>Term as Board Member</i>
*William F. Costello, M.D.	1958	1949-1958
Andrew P. Dedick, Jr., M.D.	1973	1961-1973
Consultant to The Chairman of the Board		
Irving P. Borsher, M.D.	1965	1950-1965

\*Deceased October 4, 1976



# New Jersey State Medical Underwriters, Inc. Medical Inter-Insurance Exchange of New Jersey

Vincent A. Maressa, Secretary/Treasurer

(Reference Committee "C")

At this writing the New Jersey State Medical Underwriters, Inc. and the Medical Inter-Insurance Exchange of New Jersey have issued in excess of 5,200 policies covering over 4,800 physicians, and about 450 professional corporations. Your "Company" has roughly \$20 million in surplus payments and has premium billings of about \$23 million. Of the 4,800 physicians 3,290 are rated as class 2 or lower in risk classification. This represents a favorable risk selection mix of 68.5 percent as opposed to surgical classes of 31.5 percent. The annual operating budget is 6 percent of premium in comparison to the 12.5 percent allocated to the previous carrier. This means an additional 6.5 percent will be available for loss control purposes under the captive company.

Obviously, we have no loss data at the present time and are awaiting the receipt of data from Chubb and the Insurance Department relative to years 1961 through 1976.

We believe we are cautiously optimistic in projecting an enlargement of enrollment of 1,000 insureds by February 1, 1978.

The "Company" is indeed a unique project. With your participation it can and will succeed. With the enactment of rational legislation, innovative management, fiscal responsibility, and realistic risk management, it will thrive and provide a singular service to the practicing physicians of New Jersey.

Filed (page Tr 133)

# Nominations for Emeritus Membership

(Reference Committee "H")

The following nominations for election to emeritus membership at the 1977 Annual Meeting have been received from the component societies. Conforming to the provisions of Article IV, Section 6, of the Constitution, all nominees are now and have been members in good standing of a component society for at least twenty years, and by reason of age or infirmity have retired from the active practice of medicine. All are emeritus members of their respective component societies.

## Atlantic County

Harold J. Bayer, M.D., Margate City; Age 69  
Roland T. deHellebranth, M.D., Ventnor City; Age 75  
Orazio J. DeSantis, M.D., Amarillo, Texas (formerly Ocean City); Age 66  
Maurice B. Gordon, M.D., Ventnor City; Age 60  
Isaac E. Leonard, M.D., Margate City; Age 66  
Josiah C. McCracken, Jr., M.D., Center Harbor, N.H. (formerly Atlantic City); Age 64  
Hilton S. Read, M.D., Ventnor City; Age 77  
Charles A. Saseen, M.D., Atlantic City; Age 66  
David B. Scanlan, M.D., Ventnor City; Age 62  
F. Rolfe Westney, M.D., Margate City; Age 77

## Bergen County

Mark E. Branon, M.D., Watchung; Age 72  
James S. Brescia, M.D., Saddle River; Age 66  
Margaret L. Galotta, M.D., Hackensack; Age 66  
Werner Gould, M.D., Hackensack; Age 79  
Willard H. Somers, M.D., Tenaflly; Age 67

## Burlington County

Arthur B. Peacock, M.D., Moorestown; Age 70

## Camden County

Wilmer F. Burns, M.D., Audubon; Age 68  
Ralph K. Bush, M.D., Cherry Hill; Age 76  
James R. Eynon, M.D., Haddonfield; Age 62  
Edward A. Y. Schellenger, M.D., Merchantville; Age 73

## Essex County

Chester B. Allen, Jr., M.D., Montclair; Age 69  
Joseph D. Barbella, M.D., Newark; Age 65  
Lewis W. Brown, M.D., Newark; Age 78  
Anthony P. Caggiano, Sr., M.D., Upper Montclair; Age 69  
Robert J. D'Agostini, M.D., Maplewood; Age 63  
Pasquale Dante, M.D., Short Hills; Age 66  
Nicholas V. Del Deo, M.D., Newark; Age 83  
John H. Donnelly, M.D., Bloomfield; Age 67  
Robert P. Fruchtbaum, M.D., Nutley; Age 69  
Elias Livingston, M.D., South Orange; Age 66  
Robert B. Marin, M.D., Montclair; Age 68  
Augustus J. McKelvey, M.D., Millburn; Age 73

Irving Ocheret, M.D., East Orange; Age 66  
Maximilian Perlman, M.D., Nutley; Age 67  
Nicholas L. Pollis, M.D., Asbury Park; Age 75  
Arnold J. Rosenthal, M.D., Union; Age 66  
Oscar J. Rosenthal, M.D., Livingston; Age 64  
George G. Salmon, Jr., M.D., Short Hills; Age 62  
Sven E. Svenson, M.D., North Caldwell; Age 65  
Henry A. Toczek, M.D., East Orange; Age 79  
William R. Ward, M.D., Chatham; Age 69  
David Weiner, M.D., Irvington; Age 65  
John A. Zingali, M.D., Cedar Grove; Age 66

## Gloucester County

Irving J. Stewart, M.D., Swedesboro; Age 71

## Hudson County

Samuel E. Feinman, M.D., Jersey City; Age 59

## Middlesex County

Alfred J. Barbano, M.D., New Brunswick; Age 65  
Frank E. Bristol, M.D., Jamesburg; Age 64  
Bernard M. Kramer, M.D., Perth Amboy; Age 63  
Louis R. Panigrosso, M.D., Perth Amboy; Age 78

## Monmouth County

John P. Mohair, M.D., Lakewood; Age 68  
Edward R. Neary, M.D., Colts Neck; Age 65

## Morris County

Joseph P. Bochenek, M.D., Netcong; Age 67  
Antoinette C. Parry, M.D., BelleAir Beach, Fla. (formerly Madison); Age 67  
Allen A. Parry, M.D., BelleAir Beach, Fla. (formerly Madison); Age 68

## Ocean County

James B. Goyne, M.D., Haven Beach; Age 65  
Blackwell Sawyer, Sr., M.D., Island Heights; age 77

## Passaic County

Bernard F. Alpren, M.D., Paterson; Age 64  
Norbert Beim, M.D., Fair Lawn; Age 69  
A. Hobson Davis, M.D., Tucker, Ga.; Age 78  
Anthony L. Esposito, M.D., Clifton; Age 70  
Paul B. Ferrary, M.D., Totowa; Age 68  
Robert J. Floody, M.D., Wayne; Age 66  
Charles A. Nuzzolo, M.D., Paterson; Age 69  
Charles A. Priviteri, M.D., Hackensack; Age 67  
Thomas A. Sanfacon, M.D., Paterson; Age 75  
Jacob R. Schwartz, M.D., Fair Lawn; Age 69

## Somerset County

A. John Bambara, M.D., Somerville; Age 68  
John L. Spaldo, M.D., Bridgewater; Age 66  
Alan J. Stalow, M.D., Somerville; Age 67

#### Sussex County

Lester R. Eddy, M.D., Sussex; Age 70  
John E. Longnecker, M.D., Sparta; Age 71

#### Union County

Hilde Baruch, M.D., Elizabeth; Age 73  
Max S. Black, M.D., Linden; Age 67  
Sydney H. Carsley, M.D., Cranford; Age 66  
Norman T. Crane, M.D., Plainfield; Age 76  
Max Ehrlich, M.D., Elizabeth; Age 68  
Francis Figliolino, M.D., Rahway; Age 68  
Casimir F. Gadomski, M.D., Elizabeth; Age 70  
James C. Hanrahan, M.D., Shelter Island, N.Y. (formerly Elizabeth); Age 63  
Edmund M. Hartman, M.D., Plainfield; Age 65  
Samuel M. Hoch, M.D., Jamesburg; Age 65  
Granville L. Jones, M.D., Summit; Age 77  
Elton W. Lance, M.D., Rahway; Age 79  
Alexander Lewis, M.D., Rahway; Age 69  
Edward O. MacDonald, M.D., Mt. Arlington; Age 63  
Frank M. Mastroianni, M.D., Hillside; Age 65  
Paul T. McAlpine, M.D., Bridgewater, Ct. (formerly Summit); Age 69  
Joseph Sadoff, M.D., Elizabeth; Age 72  
Abraham Strom, M.D., Plainfield; Age 89  
Michael Taranto, M.D., Bernardsville; Age 69  
Stanley Tolor, M.D., Elizabeth; Age 79  
Arthur T. Willetts, M.D., Short Hills; Age 67  
Jerome M. Wolff, M.D., Plainfield; Age 67

#### Warren County

Walter A. Boquist, M.D., Phillipsburg; Age 65

**Approved (page Tr 141)**

#### Sussex County

A. Walter Murdock, M.D., Sparta; Age 59

#### Union County

A. Starr Ingram, M.D., Westfield; Age 69  
Max B. Rosenblatt, M.D., Elizabeth; Age 63  
Bertold Salzmänn, M.D., Linden; Age 66  
Mario J. Scalessa, M.D., Summit; Age 62

**Approved (page Tr 141)**

## Supplemental #2

The following additional nominations for election to emeritus membership have been received:

#### Essex County

Ralph E. Rosamilia, M.D., East Hanover; Age 71  
Joshua L. Seidman, M.D., Millburn; Age 72

#### Somerset County

Robert E. Bennett, M.D., Skillman; Age 64  
John S. Hegeman, M.D., Somerville; Age 54

**Approved (page Tr 141)**

## Supplemental Report #1

The following additional nominations for election to emeritus membership have been received:

#### Bergen County

Reginald F. Seidel, M.D., Nantucket, Mass. (formerly Englewood); Age 64

#### Middlesex County

John H. Rowland, M.D., New Brunswick; Age 87

#### Passaic County

Edita Sporer, M.D., Clifton; Age 65  
Raymond R. Stoltz, M.D., Upper Montclair; Age 80  
Leonard J. Trilling, M.D., Chevy Chase, Md. (formerly Paterson); Age 70  
Jack C. Warburton, M.D., Laguna Niguel, Calif. (formerly Wyckoff); Age 71  
Miriam H. Winkler, M.D., Fair Lawn; Age 58

## Supplemental #3

The following additional nominations for election to emeritus membership were received:

#### Hudson County

Frank Roy Arndt, M.D., Guttenberg; Age 70  
Anthony John Balsamo, M.D., Bayonne; Age 64  
Silverino V. DeMarco, M.D., Sea Girt; Age 63  
Louis De Rosa, M.D., Union City; Age 65  
Philip Greenberg, M.D., Ormond Beach, Florida; Age 74  
John Steven Madaras, M.D., Short Hills; Age 77  
Edgar Allen Poe Peters, M.D., Jersey City; Age 78  
Charles Louis Quaglieri, M.D., Hoboken; Age 65  
Adalbert Stein, M.D., North Bergen; Age 83  
Herman L. Taft, M.D., North Bergen; Age 71  
Sophia L. Halpern, M.D., West New York; Age 85

**Approved (By action of the House)**



# New Jersey Foundation for Health Care Evaluation

Charles I. Nadel, M.D., President

Report to the House of Delegates, MSNJ, May 1977

The year since the last Annual Meeting of The Medical Society of New Jersey has been most active for your Foundation. On the Support Center side of our functions, there are now four Conditional PSROs in our State (Area I: Morris, Sussex, Warren; Area II: Passaic; Area IV: Essex; and Area VIII: Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, and Salem). In addition, three previously unfunded areas (III: Bergen; V: Hudson; and VI: Union) have concluded negotiations with HEW, and have been designated as Planning PSROs. According to the original timetable, New Jersey now should have all eight of its areas covered with funded PSROs. However, as you know, a poll concerning the Central New Jersey PSRO (Area VII: Hunterdon, Mercer, Middlesex, Monmouth, Ocean, and Somerset) was lost. As a result, the Secretary of HEW was unable to designate a Conditional PSRO in that area. Thanks to the initiative and interest which remains in the area, a new physician group has gathered together for the purpose of submitting a new proposal for Area VII. The deadline for filing, this spring, may well prove to be the last call for physician groups to respond to the PSRO challenge. The Foundation salutes both the hard work of the disbanded Central New Jersey PSRO and the undaunted determination of the new group. We continue to support all PSRO work in the State. It may be of some interest to note that the four Conditional PSROs cover areas containing about 3,400,000 people. The other four areas have over 4,000,000 population, or more people than 32 of our sister states. On this basis, less than half of our State is covered with Conditional PSROs. This indicates a great deal of work yet to be done for the PSRO organizations in those areas. It also points up the need for the continuation of a supportive and coordinating body to continue to function. The new areas have a tremendous amount of "catching up" to do, since instructions and regulations are being issued at accelerated rates. They also need support as they

prepare to implement the review system in their hospitals. The Conditional PSROs are deeply involved in their review work, so that their personnel is limited in the amount of guidance and help which they can offer to the newer units.

On this basis, this Foundation intends to petition HEW for continuation of our work as a statewide Support Center for another year. The policy of the Bureau of Quality Assurance at present is to discontinue the direct funding of statewide Support Centers at the end of the current fiscal year, which occurs on September 30, 1977. Beyond that date, Support Centers can function through subcontracts with existing PSROs. Since PSROs in more than half of New Jersey will be in no position to do this come next October, such an arrangement will be unrealistic for our State. We will request the continued support of The Medical Society of New Jersey and the New Jersey Association of Osteopathic Physicians and Surgeons in this effort. We appreciate our relationships with MSNJ, including the regular avenues of communication afforded us through the "columns" of *The Journal* and *Membership Newsletter*.

NJFHCE is also pursuing the possibilities of working with the State Professional Standards Review Council, which is in formation, and will begin its functions soon. Since these functions include coordination, evaluation, and problem-solving involving New Jersey PSROs, we feel that the experience and established relationships of the Foundation should be of value to State Council. There is also interest in many areas in the progression of the quality assurance procedures of the PSRO review system into the field of non-Federal patients. NJFHCE, in concert with PSROs, continues to investigate this concept.

With the growth of already existing PSROs in New Jersey has come experience in areas where none previously existed. In the past year the

Foundation has assisted these organizations by providing assistance in training coordinators and physician advisors, and in brochure development.

All the above assistance was geared toward strengthening the peer review process. The early indications from the more experienced PSROs are that the system is working under physician direction and control. This was our goal.

A great bulk of Foundation effort was generated in assisting the areas without PSROs. This has also been accomplished with physicians and Foundation staff working together to achieve obtaining federal monies for county MD and DO societies'-sponsored PSROs.

The most critical area of Foundation achievement has been the unification of physician-sponsored PSROs in New Jersey that act in concert and view the Foundation as a forum where issues and activities are coordinated and approached as a single entity. We have seen this actually develop and work much to the advantage of the State's physicians. This occurs while each PSRO remains autonomous and local control is maintained. Examples of this are shown in PSROs' statewide approach to data, Memoranda of Understanding with State and Federal agencies, and finally, toward a statewide approach to private insurance companies for review of their patients.

In all humility, the Foundation claims some of the credit of having New Jersey PSRO physicians working together is an achievement, one that appears unique in this country; similar opportunities existed in other states but the same results as New Jersey have not been achieved.

The elimination of federal funding in October of 1977 for Support Centers is quite evident. The Foundation physicians feel the PSRO program in New Jersey is only now the "tip of the iceberg" and with or without federal funding, the Foundation needs to exist. The evolution of PSROs from acute care hospital review (which is beginning to occur throughout New Jersey) to nursing home review, to ambulatory review, and

a multitude of what appears as other PSRO activities is mind-boggling.

The void that could exist in the next year on a State basis will certainly not lend itself to present and continued progress that will be attained.

In short, the State of New Jersey and its physicians have exemplified themselves to date and have been a credit to gaining national recognition. The Foundation feels that it somehow has forwarded this recognition.

Recent realignment of the structure of DHEW makes long-term predictions difficult. A Health Care Financing Administration has been established, incorporating the Bureau of Health Insurance (Medicare), the Medical Services Administration (Medicaid), and the Bureau of Quality Assurance (including PSRO). Hearings on Bill H. R. 3 (Representative Rostenkowski, Illinois) were concerned with the potential role of PSRO in the detection of fraud and abuse, as exemplified by the so-called "Medicaid Mills." The attention, concern, and participation of practicing physicians must be directed to these and other governmental efforts. We consider this an important role for NJFHCE.

There is a good deal of Foundation participation on the State level, as well. New Jersey has a very active and vigorous Department of Health. P. L. 93-641, the Health Care Planning and Resources Development Act (which established the Health Systems Agencies), has a counterpart found in the New Jersey statutes on planning and development. The planning division of the Department of Health is conducting a variety of studies via many committees. Among these are Committees on Elements of Cost; on Alternate Coverage; on Alternative Health Delivery Systems; the Technical Advisory Committee on Health Data, on Confidentiality, and on Health Maintenance Organizations. We participate in all of the above, and in so doing, we represent the practicing physicians of New Jersey, both as members of MSNJ as well as the Foundation. Most of these activities range beyond the field of PSRO. Our unique arrangement *as a Foundation* gives us wide latitude which would be impossible under a Federal Support Center contract alone.

*Foundation Activities*—More than ever this last year has brought about Foundation involvement in non-PSRO activities on different fronts.

The main activity this year has been the investigation and involvement in the arena of prepayment, specifically the recent phenomenon in New Jersey of developing health maintenance organizations. A concept for the last ten years, since 1974 HMOs have expanded in New Jersey with a tremendous amount of federal funding. (New Jersey is the leading state in receiving federal funding for HMO activity.)

Our Annual Reports of 1975 and 1976 referred to our interest in the Individual Practice Association (IPA) variation of the Health Maintenance Organization (HMO) concept of prepaid health care. The response of our colleagues two years ago indicated only isolated areas of interest. Within the past six months, however, physicians in such areas as Middlesex and Mercer Counties have expressed a good deal of concern, as they became aware that HMOs are here in New Jersey. Thanks to the vision of those who planned the development of this Foundation, and augmented by the resolution of the Board of Trustees of The Medical Society of New Jersey of March 21, 1976, our IPA Committee, chaired by Dr. Richard Lang, has been proceeding with investigating IPA, HMO, and the implications and options inherent in the prepaid concept. The HMO Act of 1973, as amended in 1976, has given a new thrust to this "alternative" system by virtue of what is known as the "dual option" provision. An employer with 25 or more workers must offer his employees the choice of joining an HMO (or IPA) where such facility is present. The employees must be given the choice of membership in the prepaid format or the indemnity-type coverage traditionally available. This arms the HMO or IPA with a substantial marketing tool. Industry and labor are well aware of this law and its implications for the negotiation process between employers and unions. The concern of industry with the increasing cost of the health benefits package included in the wage structure negotiated for the employees is mounting across the nation. A report from our IPA Committee will be available at the Annual Meeting of MSNJ.

The coupling of federal dollars with increased support by the Department of Health and industry at large has begun to show the fruits of their labors, especially in certain parts of New Jersey. What this is beginning to mean to segments of the physician community is that they are finding themselves starting to be in competition with closed-panel HMOs for their patients.

The Foundation, through The Medical Society of New Jersey, has begun to devote its time and money to investigating the entire scope of HMOs—what is happening, how it affects New Jersey's practicing physicians, and more importantly, how the practicing physician can compete with closed-panel prepayment plans.

From our research and information gathering, the early indications are that the practicing physicians, through the development of Individual Practice Associations (IPAs), can compete and maintain the fee-for-service principle. The Foundation, with the assistance of consultants and physicians throughout New Jersey, will continue to educate physicians on the alternatives as well as to develop a model to benefit those physicians who want to explore the IPA concept further.

Only with the support of organized medicine can this research be realized.

Other Foundation activities range from involvement with committee work of Foundation physicians who serve on Blue Shield, the Department of Health, and Health Systems Agencies, to name a few, to the increasing legislative activities dealing with PSRO and HMO legislation, as well as an interest in Medicaid and Medicare activities.

A variety of internal Foundation committees touch many areas of the health care system in New Jersey with all committee work internally and externally geared to involvement of what goes on in the mainstream of the health care delivery system in our State, as well as in the entire country. To this end, Foundation physicians have, at no remuneration to themselves, devoted their energies on behalf of the over 11,000 physicians in New Jersey.



Though small, the Foundation staff is very active. Our services in technical assistance, information-sharing, and other areas are as busy nationwide as in New Jersey. PSRO Manuals for the Review Coordinator and the Physician Advisor, developed here, have had wide distribution. These, plus our original Book of Standards, account for over 900 volumes having been issued. We are represented on the Board of Directors and on many committees of the American Association of Professional Standards Review Organizations. Our reports on the meetings of the National Professional Standards Review Council are read across the nation. Mr. Tom Crane and Mrs. Patricia Houston, R.N., helped to establish and develop advisory committees for Executive Directors and Review Coordinators for AAPSRO. Mrs. Houston has achieved a national reputation as an authority on utilization review. She is involved in training and technical assistance activities on many levels, in New Jersey and elsewhere.

The continued interest and faithful performance of our Officers, Executive Committee, and Board of Trustees are the main strength of this organization. If nothing else, the participation of so many wise and experienced practicing physicians should indicate the value of this enterprise. They represent all regions of the State and many fields of medical interest. Despite the demands on their time, they continue to provide guidance, wisdom, and devotion. Their main concern remains the interest of their fellow physicians in the delivery of quality medical care to the citizens of New Jersey.

The New Jersey Foundation for Health Care Evaluation has come a long way since its inception in December of 1972. There is still a good deal of work to be done. Plans for restructuring of the "health care system" are proliferating rapidly, as much in Trenton as in Washington. The need for an "arm" of MSNJ and NJAOPS to keep track of and analyze the variety of influences on you and your patients will not disappear. The foresight of those who set in

motion the founding of NJFHCE has proved to be most accurate in the intervening years. Such perceptiveness should be preserved, as the forces of accountability, quality assurance, cost restraints, and "alternative delivery systems" gather strength. As we see it, the essential factor is, and will be, *PEER REVIEW*. Peer review is what your Foundation is all about. The activities cited above and those that will be needed in the future mean nothing without the representation of you by your colleagues.

Included in the Certificate of Incorporation of the New Jersey Foundation for Health Care Evaluation, filed April 18, 1973, is the following:

#### *Article II—Purpose*

- Promote, foster, and develop the availability of quality health care, either alone or in conjunction with individuals, doctors, hospitals, schools, or corporations, organizations, foundations, funds, institutions, or governmental bodies.
- Promote, develop, and establish standards for quality health care based upon the professionally recognized practices of physicians licensed and practicing in the State of New Jersey.
- Promote, organize, and operate peer review activities that provide objectivity in dealing with health care costs and assist in determining medical necessity and proper utilization of services encompassing the total health needs of patients according to established standards.
- Promote, develop, and coordinate involvement by the health professions in comprehensive health care planning and area medical program activities.
- Lessen burdens of government by the implementation of Public Law 92-603 as it relates to Professional Standards Review Organizations.

The above purposes, excerpted from our Certificate of Incorporation, are those being specifically addressed by the Foundation at the present time. In developing the purposes for the "new" Foundation over four years ago, the founding fathers possessed a visionary approach, one which today has become the substance of present health care realities. For their vision and progress, they are to be saluted. The continued support of organized physicians in New Jersey is needed.

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# MEMORIAL RESOLUTION

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The following resolution was received by the House with sorrowful concurrence.

John J. Bedrick, M.D.  
(1910-1976)

Whereas, Almighty God, the Supreme Author of life and action has summoned from our midst his good servant and our beloved colleague, John J. Bedrick, M.D.; and

Whereas, as a member and Fellow of The Medical Society of New Jersey and an Alternate Delegate to the AMA, Doctor Bedrick rendered uniformly high and valuable service to The Medical Society of New Jersey and the people of our State; and

Whereas, by his understanding, wit, depend-

ability, and kindness he won the affectionate esteem of all who knew him; now therefore be it

RESOLVED, that The Medical Society of New Jersey, honoring John J. Bedrick, M.D., in death as in life, records its profound grief at his passing; and be it further

RESOLVED, that a copy of this resolution be spread upon the minutes of this meeting and that another copy, suitably prepared, be presented to his bereaved family in token of heartfelt sympathy.

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# RESOLUTIONS

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## #1

### Proportional Representation at the Annual Meeting

From the Bergen County Medical Society

(Reference Committee "A")

Whereas, the Bergen County Medical Society is required to have proportional representation at the Annual Meeting of The Medical Society of New Jersey; and

Whereas, it is conceivable that the president and president-elect might not be included to lead the delegation; now therefore be it

RESOLVED, that the President and President-Elect of the Bergen County Medical Society automatically will become delegates to The Medical Society of New Jersey; and be it further

RESOLVED, that the Bylaws of the Bergen

County Medical Society be changed to include this provision; and be it further

RESOLVED, that all component county medical societies within The Medical Society of New Jersey adopt similar Bylaws.

Rejected, because Resolution #1 violates the principle embodied in the Bylaws of the Medical Society of New Jersey that each component society shall select from among its membership whomever it wishes to represent it in the House of Delegates, so long as the number selected does not exceed the number provided for in the Bylaws. Reference Committee "A" felt that if a component society wishes its President and President-elect to be delegates, it can so provide in its bylaws or by the simple expedient of electing as President and President-Elect only persons who are delegates. (page Tr 129)

## #2

### Apportionment of AMA Delegates and Alternates

From the Gloucester County Medical Society

(Reference Committee "A")

Whereas, The Medical Society of New Jersey is entitled to seven AMA delegates and seven alternates; and

Whereas, there are five districts in The Medical Society of New Jersey and not one of the delegates or alternates now serving is from the Fifth District; and

Whereas, The Medical Society of New Jersey wishes to be a democratic organization and spread its representation throughout the State and not exclude any district; now therefore be it

RESOLVED, that one delegate or alternate be selected from each district and the remaining delegates and alternates be selected at large; and be it further

RESOLVED, that this resolution become effective as each vacancy occurs.

Rejected, because the present method of AMA delegate and alternate delegate selection functions in the best interest of the Society by permitting the selection of the most qualified persons in the Society to represent it in the AMA, rather than mandating a certain number of persons from specified geographic areas whether or not the persons are the most qualified (page Tr 129)



### #3

## Establishment of Compulsory Membership in the American Medical Association

From the Bergen County Medical Society

(Reference Committee "A")

Whereas, it is imperative that the support of the medical profession's voice through the American Medical Association before our national legislature should be as unanimous as possible; now therefore be it

mandatory condition for membership in The Medical Society of New Jersey and its federated county medical societies.

RESOLVED, that membership in the American Medical Association be established as a

Rejected, because it is the consensus that mandating membership in the AMA is not the most desirable way to maximize that membership (page Tr 129)

Resolution #4 was withdrawn by the sponsor before presentation to the House.

### #5

## Definition of Professional Liability Assessment Responsibility

From the Board of Trustees

(Reference Committee "B")

Whereas, all physicians benefit, and have benefited from a united profession; and

Whereas, directly or indirectly, all physicians are affected by the professional liability climate; and

Whereas, despite ones circumstance of employment or mode of practice, each physician has a transcending responsibility to the profession; now therefore be it

RESOLVED, that all regular dues-paying members shall be expected to honor the pro-

fessional liability assessment, except as otherwise determined by the Executive Committee when considering individual requests for exemption.

Foregoing "Resolved" amended by the Reference Committee by addition of "as provided in MSNJ's Bylaws; and be it further" after the word "exemption" and the inclusion of two additional "Resolves" as follows:

RESOLVED, that the mandatory assessment be discontinued for new members as of December 31, 1977; and be it further

RESOLVED, that The Medical Society of New Jersey continue billing those physicians who have not paid the \$200 assessment until such billings become unprofitable.

Foregoing two Resolveds further amended by the House by changing the date in the second "resolved" to May 16, 1977 and deleting "until such billings become unprofitable" in the third "resolved" to read:

**RESOLVED**, that the mandatory assessment be discontinued for new members as of May 16, 1977; and be it further

**RESOLVED**, that The Medical Society of New Jersey continue billing those physicians who have not paid the \$200 assessment.

Adopted as amended by the House and Reference Committee (page Tr 131)

## #6

### Professional Liability Assessment

From the Bergen County Medical Society

(Reference Committee "B")

Whereas, some 6,000 members of The Medical Society of New Jersey have already paid the \$200 assessment for liability control; and

Whereas, some 250 physician members will probably be declared exempt because of age or infirmity; and

Whereas, another 200 or so physicians might be declared exempt because of government or teaching affiliations which limit them to a fixed income; and

Whereas, this leaves some 1,500 physician members who have not paid the \$200 assessment; and

Whereas, it is absolutely unfair to force 6,000

physicians to bear the expense of the assessment and permit others to be allowed to omit paying this obligation; now therefore be it

**RESOLVED**, that The Medical Society of New Jersey at its Annual Meeting in May 1977 declare that the \$200 assessment is due and payable immediately by all members who have not met this obligation and who are not otherwise exempted; and be it further

**RESOLVED**, that if this obligation is not met by December 31, 1977, the recalcitrant members shall be dropped from the membership in The Medical Society of New Jersey.

Rejected—Intent embodied in amended Resolution #5, see page Tr 106 (Tr 131)

## #7

### Professional Liability Assessment

From the Burlington County Medical Society

(Reference Committee "B")

Whereas, the House of Delegates of The Medical Society of New Jersey, at its Annual Meeting held in June, 1976, approved a mandatory assessment of \$200 for the purpose of professional liability activities; and

Whereas, this mandatory assessment has no expiration date; and

Whereas, the mandatory assessment has no provision for exemption for financial hardship

or any other valid reason; and

Whereas, this mandatory assessment acts as a deterrent to recruitment of members to The Medical Society of New Jersey and its component societies; now therefore be it

RESOLVED, that the mandatory assessment

be discontinued as of December 31, 1977; and be it further

RESOLVED, that component county societies be given full power to waive permanently the \$200 assessment where circumstances warrant.

**Rejected—Intent embodied in amended Resolution #5, see page Tr 106 (Tr 131)**

## #8

### MSNJ Professional Liability Assessment

From Daniel N. Burbank, M.D., Delegate, Essex County

(Reference Committee "B")

Whereas, The Medical Society of New Jersey has already received sufficient monies to more than accomplish the stated goals of the \$200 special assessment concerning public relations, lobbying, mailings, and secretarial expenses; and

Whereas, we do not desire to decimate the Medical Society membership and cut off those physicians who have not paid from organized medicine; and

Whereas, we need all the members we can get to increase our representation and delegation to the AMA; and

Whereas, at a time when we seek more unity and desire to speak for more physicians, we should not throw out members who do not believe, in principle, with this assessment; now therefore be it

RESOLVED, that The Medical Society of New Jersey continue billing those physicians who have not paid the \$200 assessment until such billings become unprofitable.

**Rejected—Intent embodied in amended Resolution #5, see page Tr 106 (Tr 131)**

## #9

### Elimination of Two-Hundred Dollar Assessment on New Members of MSNJ

From the Essex County Medical Society

(Reference Committee "B")

Whereas, it is a generally accepted principle in a democratic society that "there should be no taxation without representation," especially in the form of unique assessments, and it is especially "un-American" in this period of

celebration of the Bicentennial of the United States of America; now therefore be it

RESOLVED, that the one-time mandatory assessment of two-hundred dollars for all



members of The Medical Society of New Jersey, made by the House of Delegates at the Annual Meeting in Cherry Hill in June of 1976,

not be interpreted as assessable for those physicians who have become first-time new members after the date of said assessment.

**Rejected—Intent embodied in amended Resolution #5,  
see page Tr 106 (Tr 131)**

## #10

### Exemption from Professional Liability Assessment

**From the Hudson County Medical Society**

(Reference Committee "B")

Whereas, no provisions were made for special exemption of physicians from the \$200 assessment for professional liability approved by the House of Delegates of The Medical Society of New Jersey in December 1975 as a voluntary assessment and in June 1976 as a mandatory assessment; and

Whereas, members who have not paid the \$200 special assessment by June 1, 1977, will be dropped from the membership rolls of The Medical Society of New Jersey; now therefore be it

RESOLVED, that members of the Society may apply to the Executive Committee of the Board of Trustees of The Medical Society of New Jersey for exemption from this mandatory assessment because of financial hardship or other valid reason upon recommendation of the physician's county medical society; and that the exemption be retroactive to January 1, 1976.

**Rejected—Intent embodied in amended Resolution #5,  
see page Tr 106 (Tr 131)**

## #11

### Exemption from Professional Liability Assessment

**From the Union County Medical Society**

(Reference Committee "B")

Whereas, at present there are no provisions for exemption from the voluntary two-hundred dollar assessment passed at the Special Session of the House of Delegates of The Medical Society of New Jersey in December, 1975 and made mandatory at the Annual Meeting of The Medical Society of New Jersey in June, 1976; now therefore be it

RESOLVED, that members of The Medical Society of New Jersey may apply for exemption

from this mandatory assessment because of financial hardship or other valid reason and that this application for exemption be decided by the Executive Committee of the Board of Trustees of The Medical Society of New Jersey on recommendation of the physician's county medical society. This resolution should be made retroactive to January 1, 1976.

**Rejected—Intent embodied in amended Resolution #5,  
see page Tr 106 (Tr 131)**

## #12 Commissions re Professional Liability

From the Bergen County Medical Society

(Reference Committee "C")

Whereas, there is a sense of disquietude among many members of The Medical Society of New Jersey relative to the medical professional liability problems; and

Whereas, at a hearing on professional liability coverage held in July 1975, attended by representatives of the New Jersey Department of Insurance, the Britton Agency was reported to have received approximately \$970,000 in commissions in 1975 for services to the Federal Insurance Company in connection with professional liability coverage; and

Whereas, the hearing officer representing the Commissioner of Insurance stated that a commission of about \$100,000 in addition to the one percent premium would be sufficient compensation to the Britton Agency; and

Whereas, the New Jersey Neurosurgical Society has expressed the opinion that \$970,000 in commission was excessive; and

Whereas, all legitimate attempts to have this matter explained satisfactorily by the Officers of The Medical Society of New Jersey have proven futile; now therefore be it

RESOLVED, that the proper spokesman for The Medical Society of New Jersey be requested to publish full details of this matter in *The Journal* of The Medical Society of New Jersey. (See attachments.)

Rejected as argumentative and serving no purpose (page Tr 133)

### Attachments

March 24, 1977

Ralph J. Fioretti, M.D., President  
Bergen County Medical Society  
170 Main Street  
Hackensack, NJ 07601

Dear Doctor Fioretti:

The Board of Trustees of the MSNJ considered your letter of March 15, 1977, along with the enclosure from the Legal and Political Affairs Committee of the Medical Staff of The Valley Hospital. The Board of Trustees directed that I should provide you and the Legal and Political Affairs Committee of the Medical Staff at Valley with a response to their letter.

In regard to the letter from The Valley Hospital Committee, I must point out that only the paragraphs which I quote below may be considered in logic, law, and reason to be "facts." The balance of the material is in the form of conclusion, opinion, or interpretation of the Committee of The Valley Hospital or perhaps, Mr. Stern.

"... In July 1975 there was a hearing on the application of the Federal Insurance Company for a revision of rates for

the Medical Professional Liability Coverage. Representatives of the State Medical Society were in attendance.

"The following facts were revealed in the course of the hearing:

"The written premiums for the policy year beginning November 1, 1974 amounted to \$14,400,000.00 and with the approximately 50% increase in premiums on November 1, 1975 the premiums amounted to about \$22,000,000.00. A commission rate of 4.5% was filed for by the agent (the Britton Agency). The commission rate had been 6% in years past. This revised commission rate amounted to about \$970,000.00 in commission for the year 1975 alone. ..."

I will now proceed to discuss the issue presented by the letter in question and will document and reference the points made as we proceed.

1. "The commission rate of 6% underlying current rates as previously approved by the Commissioner (lowered to 4.5% in the present filing) is very substantially lower than the commission and brokerage incurred for Federal and associated companies for general liability insurance. That was 15.0% in 1974." (Testimony of David G. Hartman before the New Jersey Department of Insurance, July 28, 1975.)

2. "The record, of course, does show that the commission provision underlying the proposed rates is very much lower than the 15% average commission which Federal pays for general liability insurance. I suggest that it is undoubtedly the case that were the MSNJ program handled as a matter of normal agency production, the total commission expense would be substantially higher than that shown in Exhibit A-5 (4.5%). (And, of course, as we have stated elsewhere, we believe that other expenses would increase as well.)" Letter to Philipp K. Stern, New Jersey Department of Insurance, from Newell G. Alford, Jr., General Counsel, Chubb and Son, July 30, 1975.

3. "For the reasons set forth below, we take exception to the hearing officer's recommendation that the rates provide for a commission expense of no more than 1.5%.

"As Exhibit A-7 shows, Federal Insurance Company since September 1, 1971 has been and still is contractually obligated to pay a 6.0% commission to the Britton Agency. That contract is still in effect.

"The material supporting our filing makes provision for a 4.5% commission expense because the Britton Agency has agreed to accept a commission reduction to 4.5%, if our rates increase proposal is approved.

"Under these circumstances, your acceptance of the hearing officer's recommendation on this point would disable Federal Insurance Company from performing its contract with the Britton Agency.

"Moreover, as Exhibit A-7 points out, and as I believe the hearing officer's report itself recognizes, nothing in the record of this proceeding supports the conclusion that the 4.5% commission negotiated with the Britton Agency in connection with the proposed rates is an unreasonable one.

"In fact, what the hearing officer suggests is that MSNJ could and perhaps should directly compensate the Agency for the services it performs for MSNJ and on behalf of the individual policyholders for which the Agency acts." (Letter of September 8, 1975 to Commissioner Sheeran from Newell G. Alford, Jr., General Counsel, Chubb and Son.)

4. As everyone is well aware, the Commissioner of Insurance did not adopt the recommendation of the hearing officer and did indeed approve the 1975 rate increase along with the incorporated 4.5% commission to the Britton Agency. The duty of the Insurance Department is to approve rates which are "adequate but not excessive nor unfairly discriminatory."

5. The rate filing for 1976 provided for a commission of 2.5%. Based, however, on a premium increase of 65.2% plus an increased number of insureds, it produced or would produce more than one million dollars to the broker. At the July 16, 1976 hearing conducted by Mr. Stern concerning the 1976 rate filing, he declared, "I see no value in going through a charade here and asking Mr. Hartman questions which he has previously answered to my satisfaction. As some of you know, we have a competent actuarial staff in this Department. I have asked Mr. Hartman many questions, he has submitted answers to me, and as hard as I try to knock every file down as much as I reasonably can, I couldn't find anything wrong with this filing." Page 29—Transcript of Proceedings.

6. The 1976 rate filing which included a 2.5% commission predicated on an anticipated annual premium in excess of 41 million dollars, was approved. The obligation of the Commissioner is to "approve rates that are adequate but not excessive nor unfairly discriminatory."

7. Since the commissions have always been a part of the rate filings and since the rate filings have always been approved by the Commissioner, the effect of his action is to declare the commissions as a matter of law to be adequate but not excessive. Further, since this matter is a matter of contract between Chubb and the Britton Agency, the Society has no reasonable legal basis on which to pursue the course of litigation suggested by the Committee from The Valley Hospital. A copy of the Britton Agency function under the previous MSNJ program is enclosed with this letter.

Respectfully submitted,

(Signed) Vincent A. Maressa  
Legal Counsel

July 16, 1976

The relationship of The Medical Society of New Jersey and the Joseph A. Britton Agency is different than that between the usual insurance broker and the individual policyholder. An analysis would divide it into three basic parts.

A. First would be the handling of the details for the individual physician as would be done by the average broker for new applications, changes and cancellations:

1. Handle telephone and mail inquiries with occasional personal visits with groups.
2. Supply necessary forms.
3. Upon receipt of new application or request for policy change, review and subsequently refer to company underwriter for approval and typing of policy or endorsement.
4. Review typed policy or endorsement for accuracy prior to mailing.
5. Record invoice on A.R. card or ledger.
6. Receive payment to be sent to company.
7. Follow up delinquents with cancellation requested, if necessary.
8. Follow up for renewal, a year later.

B. The second would be the additional performance as agent for the Insurance Company in accordance with the company's rules and instructions. In no way does this responsibility conflict with the responsibility of broker to the individual or to The Medical Society of New Jersey. It has been agreed that our office can more efficiently do this work with considerable economy and savings for the company. These details include:

1. Underwrite application as to qualifications, society membership, proper class, any additional charge, loss experience for possible surcharge. Many times, there must



be a follow-up for required information.

2. Review and underwrite endorsement change.
3. Do rating and coding for new policy or change.
4. Type policy or endorsement and send copy to company.
5. Compute proper premium for term less than one year and prepare invoice.
6. Deposit daily, direct to company's account, all premium payments as received.
7. Follow up delinquents for proper notice of possible cancelation with all details of final cancelation, if necessary, with copy to company.

C. The last general details, which are most important, most time consuming and expensive, and most demanding for highly qualified personnel are the duties as the broker for The Medical Society of New Jersey and for each member thereof who wants professional liability insurance coverage under The Medical Society program. Our first responsibility is to The Medical Society of New Jersey and our program, but this in no way compromises our duty or responsibility to the individual physician who elects to use our services. We feel we must operate under the rules of the Medical Society program which are also the rules of the company. Most of the rules are part of the approved filings with the New Jersey Insurance Department. Some of these duties are:

1. Maintain current up-to-date records of all net premiums for each policy with allocation as to year of coverage, class of practice, specialty and identification of additional charges, surcharge for adverse loss experience, employees' coverages, and premises liability. This record permits us to compare premium for any specialty class or charge with reported losses and subsequently report to the Committee on Medical Defense and Insurance of The Medical Society of New Jersey for the recognition of a possible change of a specialty or charge to a higher or lower costs class. Also, we are prepared for any discussion with the Insurance Company as to the approved changes and possible allocations on general rate increases.
2. Maintain current records as to number of effective policies for each specialty, each class, and each county of practice as well as partnership, group corporation and society; also, for insured employees, individual corporation endorsement and surcharge endorsements as well as for chargeable modalities such as x-ray therapy, shock therapy, or neurological procedures. We furnish reports of these records for each meeting of the Committee on Medical Defense and Insurance. This record also is necessary to complement the previously described premium record for possible changes and distribution of rate increases. It must be recognized that the average company determines that it needs an increase of a percentage of the total premium and it would be common sense expediency to do it the easiest way by charging each physician the same percent increase. However such usual procedure is not fair if we believe in a policy of placing the cost in ratio, as far as possible, to the losses for each class or specialty. Because of this system and our records, we are able to have 9 separate or different rates to cover all specialties and practices as compared to the rest of the insurance industry in New Jersey with its 5 different rates.

3. We receive most, if not all, claim reports and suits from insured physicians and many times from those who were not insured through our office at the time of the loss. Our records provide most information as far back as 1960 and if we don't have all of the necessary information we follow up with other brokers or companies to ascertain the insuring company at the time. We then refer the papers and necessary information to the proper company. This is very time consuming since most physicians want to telephone and discuss the claim before mailing papers and reports to us. We should receive about 1300 claims a year of which about 700 will be suits. In addition to the actual claim we have many other minor incidents reported so the total for us could be about 1800 a year or 36 a week which is more than 7 a day on the average.

4. For these physicians insured through our office, we retain copies of the claim or suit papers and record the claim on the county card as well as his individual claim record card. These cards are up to date as to status of the claim or suit with reserve, if open, and payments, if closed, with information as to how it was closed. A continuing review of these records affords information for loss control as to application of surcharge or just discussion with the defendant physician as to his practice with possible referral to the proper Medical Society Committee for remedial action. Again this up-to-date detailed information of current losses as to specialty, class or practice, with the records of insureds and premiums, permits us to counsel the Committee on Medical Defense and Insurance of The Medical Society of New Jersey as to changes and distribution of rate increases and also for intelligent discussion with the insurance company.

5. In addition to our current recording of losses, we receive up-to-date information on losses handled by the Employers Insurance of Wausau who was the insurer from 1-20-68 to 11-1-71. We have records on all losses reported to date. Our records for Chubb are for all losses from 9-1-71 to date. We also have records for about six years of losses of American Mutual who was the insurer from 5-1-60 to 11-1-68. We also review the continuing losses received by American Mutual on an annual basis.

6. Reports of new claims received for each specialty and class are made for each meeting of the Committee on Medical Defense and Insurance and especially for the Committee's annual report to the Medical Society House of Delegates at each year's convention.

7. Our work includes the formation and supervision of the Medical Review and Advisory Committees in the 21 counties in accordance with the rules adopted by the Committee on Medical Defense and Insurance and approved by past Houses of Delegates. This includes the assignment of an attorney for each of the 21 committees and provides that the committee serves the attorney with the advice that its work is to be confidential and considered as the work product of the attorney who would defend the defendant physician.

8. When a claim is referred to a company which uses the services of the Medical Society's review facilities, we follow up for completion of investigation. When completed, it is sent to a member of the proper county committee who usually is in the same specialty or practice as the defendant physician in the claim. We receive notification and include the claim on the agenda for the next meeting of that committee. Our office schedules the meetings of each

committee after coordinating the date with the company's claim manager, the assigned attorney, and the physician chairman of the committee. Each committee, whose membership runs between 9 and 27, is composed of outstanding physicians in the county and, as at one time, not necessarily insured under the program. The members represent most of the specialties or at least those specialties which have higher claim frequencies. When a claim is received for a specialty not represented on the committee we select a specialist from the county to serve temporarily on the committee and to act as case chairman for this particular claim.

9. A man from our office attends each meeting of every county Medical Review and Advisory Committee even when two or three are scheduled for the same date. The meeting of each committee will take about two to three hours on the average and always will be within the county. Our attendance at the many meetings, since our major counties usually have one meeting each month, involves considerable time and travel. Our office acts for the State Committee on Medical Defense and Insurance to guarantee that the rules and procedures are followed and especially to be sure claims are not settled for the expediency of the company, the attorney or the individual physician. We keep records of all meetings, decisions and final dispositions with regular reports to the State Committee.

10. One of the most important loss control features and one which can be very time consuming is our securing legal counsel or advice for procedures or potential claims. Most of our calls or letters have been from physicians insured through our office. However, we receive many requests from county medical societies, specialty groups, The Medical Society of New Jersey, and occasionally from physicians not insured through our office. We furnish to all physicians, a copy of a digest of laws and consent forms for most procedures. Occasionally we are asked to have a consent form prepared to be used for a particular procedure, many times new or even experimental.

11. We supply information to county medical societies and specialty groups in addition to the usual many reports to the Committee on Medical Defense and Insurance. We also frequently furnish speakers for county medical society meetings, specialty group meetings, and medico-legal panel discussions. We provide written articles as requested and especially a monthly article for *The Journal* of The Medical Society of New Jersey. The performance of these functions requires time spent in reading periodicals, researching new law and developments pertaining to the insurance industry and specifically the field of professional liability insurance.

12. We attend every meeting of the Committee on Medical Defense and Insurance, occasional meetings of the Board of Trustees, occasional meetings of the Medical Society Ad Hoc Committee on professional liability and the annual convention, including the reference committee to which professional liability is assigned.

13. We have been requested by The Medical Society of New Jersey to confer with legislators from other states, with representatives from other state societies, with representatives from the American Medical Association as well as with hospitals and other related health providers when there is a problem of mutual and current interest. We were asked to cooperate with and supply information to the legislative committee, chaired by Senator Greenberg, for possible remedial legislation.

14. We were asked by The Medical Society of New Jersey to assist the Connecticut State Medical Society in establishing a program in Connecticut similar to the one in New Jersey. We met many times with officials of the Connecticut Medical Society and its insurance company, Aetna. They finally adopted a program patterned after ours and we were told that Aetna adopted this new program for most of the states in which it is the primary carrier. We still serve, without fee, as consultant to the Connecticut Medical Society.

15. The State of Illinois has been in the process of starting a captive company and wants to establish a program like ours in New Jersey. We have been asked to help and in fact to send a man to run the program.

16. We believe that it has been mostly our efforts in serving The Medical Society of New Jersey and most of its members which have permitted our office to grow and to develop a reputation of a professional in this field. We are not just an insurance broker with the simple operations as described in the first basic. It is also our reputation and performance which has made it possible to keep a reputable and sound company to underwrite our program in New Jersey which is recognized as a liberal state and potentially a problem one in the area of medical professional liability. Never have we been interested in finding just any company or having selfish motives as more important than the individual physician's protection and maintenance of The Medical Society of New Jersey's loss control program. This was proved again in the past year when we lost our facilities for umbrella coverage and spent much time in finding and selecting one company from a number of them which would be representative of the desired standards for insuring members of the society.

## #13

### Legislation Concerning Professional Liability

From the Bergen County Medical Society

(Reference Committee "C")

Whereas, medical liability results from the interaction of patient and physician; and

Whereas, injury and disease cannot be treated separately from the patient; and

Whereas, there is a proportional responsibility of the patient and physician in the eventual end result of diagnosis and treatment; and

Whereas, the physicians cannot insure the total population against the vagaries of human response to diagnosis and treatment of any one individual; and

Whereas, a more equitable approach to financing protection of the patient from significant loss or misfortune is mandatory; and

Whereas, every individual is a potential patient and shares a proportional responsibility with everyone else; and

Whereas, all physicians should continue to assume only their fair share of this burden; now therefore be it

RESOLVED, that the New Jersey State Legislature address itself to this urgent and critical

condition and provide legal means to:

(a) Recognize the patient-physician relationship as unique and different from all other human interpersonal relationships.

(b) Remove medical liability from the arena of insurance claims and commercial competition.

(c) Establish a fund to compensate patients from medical liability misfortune, to be administered and controlled by an appropriate State agency.

(d) To finance the fund through annual payments proportionally obtained from providers and consumers of health services.

(e) To provide reimbursement to successful litigants including legal fees for plaintiff and defense.

(f) Provide appropriate controls, remedies and penalties for abuse, misuse, or unreasonable demand on the fund.

Rejected and referred to the Council on Legislation for informational purposes (page Tr 133)

## #14

### Assignment of Benefits by Blue Shield

From the Union County Medical Society

(Reference Committee "C")

Whereas, the 1976 House of Delegates adopted Resolution #4 which stated: "RESOLVED, that The Medical Society of New Jersey petition the Medical-Surgical Plan of New Jersey to change its contract in order to allow assign-

ment of benefits and that The Medical Society of New Jersey petition the Commissioner of Insurance to honor this contract change"; and

Whereas, the 1976 House of Delegates based



its reasoning for the adoption of this Resolution on the facts stated in the Resolution to the effect that, although at one time a majority of the physicians in each county had to be participating physicians in order for the Plan to be validated, that ruling was negated by court action in 1964; and

Whereas, despite the adoption of Resolution #4 by the 1976 House of Delegates, the Medical-Surgical Plan of New Jersey has refused to honor the just desires of the majority of the

physicians in New Jersey; now therefore be it

**RESOLVED**, that The Medical Society of New Jersey directly petition the Commissioner of Insurance of the State of New Jersey to order the Medical-Surgical Plan of New Jersey to alter its contract to permit assignment of benefits to all physicians.

**Rejected as a disservice to participating physicians of Blue Shield (page Tr 133)**

## #15

### Acceptance of Standard Claim Forms

**From the Mercer County Medical Society**

(Reference Committee "C")

**RESOLVED**, that the Medical-Surgical Plan of New Jersey be requested to accept the standard claim forms, as established by the American Medical Association, for reimbursement of

medical insurance.

**Referred to the Council on Medical Services (page Tr 133)**

## #16

### Increase Rider J Coverage for Pathological Laboratory Services

**From the Mercer County Medical Society**

(Reference Committee "C")

Whereas, the \$25 allowance for Rider J coverage for pathological laboratory services was adopted many years ago; and

Whereas, the cost of individual tests and extent of pathological laboratory services have increased tremendously; and

Whereas, payment for these out-patient services allows a higher quality of medicine to be practiced, it would lessen the pressure for hospitalization; and

Whereas, this would be overall less costly to the

third party carrier; now therefore be it

**RESOLVED**, that the House of Delegates of The Medical Society of New Jersey go on record as requesting the Hospital-Service Plan of New Jersey and the Medical-Surgical Plan of New Jersey to increase its limit to \$200 on Rider J for pathological laboratory services.

**Rejected (page Tr 133) Note: The Reference Committee felt that there should be a program of information for employers and employees concerning the availability of various Rider J contracts.**

## #17

### Joining the Medical Inter-Insurance Exchange

From the Morris County Medical Society

(Reference Committee "C")

Whereas, the Medical Inter-Insurance Exchange is established for all physicians in the State of New Jersey; and

Whereas, all physicians have an opportunity to join at the time of its establishment; and

Whereas, the activation of the Re-Insurance Authority provided all physicians with a voluntary choice; now therefore be it

RESOLVED, that The Medical Society of New Jersey urge the Board of Directors of the MIIE to determine that physicians joining the MIIE prior to June 30, 1977, shall be considered charter members; and be it further

RESOLVED, that anyone joining the MIIE after the above date shall be required to pay an additional surcharge of 10% above and over the required initiation fee; and be it further

RESOLVED, that any physician first establishing his practice in the State of New Jersey shall be exempt from this requirement if they

join the MIIE within three months of opening their office; and be it further

RESOLVED, that The Medical Society of New Jersey urge the Board of Directors of the MIIE to determine that the MIIE will accept no physician as an insured unless he/she is, or becomes, a member of The Medical Society of New Jersey or the New Jersey Osteopathic Society.

Referred to the Board of Trustees (MSNJ), along with amendments proposed by the Reference Committee (page Tr 133) and the following suggested "resolved" (proposed from the floor of the House) as a substitution for the original four "resolveds:"

That the Medical Society of New Jersey and the Board of Directors of MIIE do all in their power to get the acceptance of the insurance commissioner of New Jersey of a plan whereby there would be a certain percentage reduction in the yearly premium payment for those physicians in the MIIE plan who are members of The Medical Society of New Jersey or of the New Jersey Society of Osteopathic Physicians and Surgeons.

## #18

### Physicians Starting Practice in New Jersey

From the Morris County Medical Society

(Reference Committee "C")

Whereas, present insurance rates have increased the cost of starting practice for young physicians in the State of New Jersey; and

Whereas, we now have our own insurance company underwriting professional liability insurance in the State of New Jersey; now therefore be it

RESOLVED, that The Medical Society of New Jersey investigate ways that a fund be

established by the Inter-Insurance Exchange to loan the first year's premiums and surplus capitalization monies to all physicians just completing residency training who establish a practice of medicine or surgery in New Jersey to be paid back over a period of three years at no interest.

Referred to the Board of Trustees (MSNJ) along with the Reference Committee's proposed amended "resolved" (page Tr 134)

## #19

# Continuing Medical Education

From the Burlington County Medical Society

(Reference Committee "D")

Whereas, the Constitution of The Medical Society of New Jersey states, among its purposes, "to federate and organize the medical profession of the State of New Jersey; . . . to advance the art and science of medicine, elevate professional standards, safeguard the interests of, and promote friendly relations among, members of the medical profession"; and

Whereas, the Bylaws were amended in 1973 to require that members must complete 150 hours of acceptable programs of continuing medical education during each three-year period of membership, said programs "to be administered by the Committee on Medical Education in accordance with policy approved by the Board of Trustees and affirmed by the House of Delegates"; and

Whereas, the accreditation process for having programs accredited has been delegated to the Academy of Medicine of New Jersey and is financially supported by funds derived from the dues of every member of The Medical Society of New Jersey (currently \$25,000 allocated for the 1976-77 Society year); and

Whereas, the component county medical societies are working diligently toward achieving and maintaining unity within the medical profession and assisting its members in acquiring the aforesaid goal of continuing medical education credits, but continuously are being hampered by ever-increasing cumbersome paperwork and regulations promulgated under the accreditation process, including, but not limited to, the requirement that all programs must be submitted along with supporting data to the Academy of Medicine of New Jersey at least 90 days in advance of a planned program; and

Whereas, it is difficult, if not sometimes down-

right impossible, for the component county medical societies fully to plan a program and submit all required data at least 90 days in advance, inasmuch as the programs are being arranged by full-time practicing physicians trying to plan within the budgetary limits of the county society; now therefore be it

RESOLVED, that the Committee on Medical Education recommend, and the Board of Trustees and the House of Delegates approve, effective immediately, that all continuing medical education programs of any component county medical society be given blanket approval for Category I of continuing medical education credits; and be it further

RESOLVED, that the Committee on Medical Education, the Board of Trustees, and the House of Delegates direct their efforts in unity and support of the component county medical societies by reducing the 90 days' advance notice requirement down to 30 days' advance notice; and be it further

RESOLVED, that accreditation requests for continuing medical education programs from the component county medical societies be expeditiously processed wherever and whenever submitted should unforeseen circumstances develop which bring about an even shorter notice for accreditation but such programs are deserving of accreditation; and be it further

RESOLVED, that if the foregoing requests are not adopted and implemented immediately, then, in such event, all funds directed to the Academy of Medicine of New Jersey for its continuing medical education activities be withdrawn by The Medical Society of New Jersey; and be it further

RESOLVED, that the Committee on Medical Education be ever mindful that it is created to



help the members of the medical profession and to foster voluntary compliance with the Bylaws regarding continuing medical education toward the goal that the physicians are indeed encouraged to continue membership in organized medicine via The Medical Society of New Jersey and to comply willingly with the continuing

medical education requirements.

**Rejected (page Tr 135).** Reference Committee "D" felt that the problem raised in the resolution has been addressed by the Academy of Medicine of New Jersey and that a county medical society can obtain approval for medical education programs within thirty (30) days or less.

## #20

### Hospital Autopsies

From John Winslow, M.D., Delegate, Essex County

(Reference Committee "E")

Whereas, careful and complete autopsy examinations are essential for the proper evaluation of medical care and treatment, the understanding of disease processes, and for accuracy in death statistics and trends therein; and

Whereas, very often it is impossible to give accurate death diagnoses without careful post-mortem examination by skilled pathologists, and death certificate diagnoses arrived at by a judgmental basis are usually not very valid for health statistics; and

Whereas, even when the cause of death is quite clear, an autopsy often gives much additional helpful information to the treating physician and the family, and also added valuable statistical information; and

Whereas, there is the precedent, in Germany and some of the Scandinavian countries, that hospital autopsies are automatically done unless there is specific refusal during the first six hours after the occurrence of death, and also many insurance companies in these countries, when there is refusal for autopsy, have been known to decline payments by stating that the medical records are "incomplete"; now therefore be it

RESOLVED, that The Medical Society of New Jersey actively promote legislation in the New Jersey Legislature to authorize and direct

hospitals to do complete autopsies on all hospital deaths with certain rare exceptions as might be defined, with a provision for basic reports to be sent automatically to next of kin or other authorized representatives; and be it further

RESOLVED, that The Medical Society of New Jersey, if it is impossible at this time to get legislation for routine autopsy examinations, should develop an effective educational campaign for the general public, funeral directors, and also, very importantly, for physicians, the purpose of the endeavor being to make autopsies become the expected and accepted procedure with all hospital deaths; and be it further

RESOLVED, that in all cases of hospital deaths, the attending physician (presumably having a close communicative relationship with the family) must be the only medical person to request an autopsy permission and in no case should this task be given to nursing, intern, resident, panel physician or other hospital personnel. If the attending physician is not available to perform his duty, even by telephone, his alternate covering attending or some other attending on the staff should make the request, although this procedure is much less effective than when the deceased patient's regular physician personally makes the request.

**Rejected as an infringement of privacy and individual rights (page Tr 136)**

## #21

### Reporting of Medicaid/Medicare Fees

From the Mercer County Medical Society

(Reference Committee "F")

Whereas, the reporting of physicians who allegedly made greater than \$100,000 on Medicaid and Medicare patients per year has been widely publicized in the news media; and

Whereas, this reporting has been manifestly inaccurate, frequently confusing amounts paid to groups with amounts paid to individuals; and

Whereas, this publicity is universally adverse, designed to imply the physician is abusing the system financially; and

Whereas, this type of disclosure is highly discriminatory; now therefore be it

RESOLVED, that the House of Delegates of The Medical Society of New Jersey request the appropriate agency that accuracy in releasing such information is imperative and the medical profession should not be singled out.

Reference Committee proposed the following substitute resolution:

Whereas, the reporting of physicians' Medicaid and Medicare reimbursed fees has been widely publicized in the news media; and

Whereas, this reporting has been manifestly inaccurate, frequently confusing amounts paid to groups with amounts paid to individuals; and

Whereas, this type of disclosure is frequently inaccurate and susceptible to gross distortions and inflammatory innuendo, casting aspersions by the media and the public concerning the vast majority of honest and ethical physicians; now therefore be it

RESOLVED, that the House of Delegates of The Medical Society of New Jersey oppose the indiscriminate release of such gratuitous information unless it has relevance to a specific allegation of abuse, fraud, or unethical practice, and be it further

RESOLVED, that the Board of Trustees and our AMA Delegates take steps to express our concern about this action.

Substitute Resolution adopted (page Tr 138)

With the concurrence of the House Resolution #22 was withdrawn by the sponsor.

## #23

### National Catastrophic Health Insurance Plan

From the Essex County Medical Society

(Reference Committee "F")

Whereas, methods have been worked out in our country to provide general medical care on a fairly satisfactory basis for all who need it but there are almost no remedies for the devastating costs that catastrophic illness can bring; and

Whereas, the chief public concern in health matters is the cost of catastrophic illness which can be devastating to family assets; and

Whereas, "Major Medical" benefits are an established partial answer to severe or cata-

strophic illness for those who can afford it on a private or employee benefit basis, but are not available to many people and are a limited benefit to most; and

Whereas, the United States Government has seen fit to be involved deeply with one type of catastrophic illness, namely severe renal disease requiring frequent dialysis; now therefore be it

RESOLVED, that The Medical Society of New Jersey, through a resolution to be presented by its delegates at the next Annual Meeting of the American Medical Association, direct that the American Medical Association assume the leadership in the urgent development of Cata-

strophic Health Insurance legislation in the present session of the United States Congress to provide a plan, as a separate legislative entity, to cover the entire United States population against the devastating financial losses from defined catastrophic illness; and be it further

RESOLVED, that the Catastrophic Health Insurance Plan (C.H.I.P.) to be developed would involve the private insurance industry, primarily, with elements of government co-insurance and re-insurance based on socioeconomic and other limiting factors to be worked out on an equitable basis.

**Rejected (page Tr 138)**

## #24

### Generic Drug Prescribing and Substitution

**From John Winslow, M.D., Delegate, Essex County**

(Reference Committee "F")

Whereas, there is a revolution taking place in the whole field of pharmaceutical dispensing, particularly in regard to cost factors, truth-in-purchase, drug advertising, and other consumer freedom-of-information mechanisms; and

Whereas, it is still just as true now, as it was in 1974, that a substitute generic drug may or may not be the therapeutic equivalent of the brand-name medication originally prescribed; the big factor being the perspicacity and intellectual honesty of the dispensing pharmacist; and

Whereas, it is apparent that socioeconomic and consumer factors, not necessarily for the correct nor best reasons, have made the generic prescribing and substitution of prescription drugs a subject whose "time has come" and that we physicians may have to accept, even though the 1974 MSNJ House of Delegates approved Resolution #20, submitted by Gustav Ibranyi, M.D., through the Essex County Delegation, which Resolution stated that The

Medical Society of New Jersey should "support the policy of freedom of choice of drugs by the physician" and saying that the treating physician "should have the choice (in all private paid, insurance paid, and government paid programs) of deciding whether or not to prescribe generically or by brand name"; now therefore be it

RESOLVED, that The Medical Society of New Jersey give its cautious approval to generic prescribing and substitution of high-grade therapeutically equivalent generic drugs for brand-name prescriptions, but it must make certain in so doing that the following safeguards are part of any agreement:

a. The treating physician, by using specific notation for a special brand-name drug, shall not have his prescription drug substituted by a generic equivalent without his being contacted by phone by the dispensing pharmacist and also giving his oral approval for the substitution.



b. Each and every prescribed medication shall be labeled on the patient's drug container with the name of the drug therein and also, in the case of generic drugs, with the name of the manufacturer of said drug.

c. In no case may a drug higher priced than that intended by the prescribing physician be substituted without specific authorization from

the physician; and be it further

RESOLVED, that The Medical Society of New Jersey record itself as welcoming the trends toward better consumer information concerning medications.

**Rejected.** The House voted continued support of Resolution #20 approved by the 1974 House of Delegates (page Tr 138)

## #25

### Blood Replacement

From the Essex County Medical Society

(Reference Committee "G")

Whereas, the American Association of Blood Banks and the American Red Cross have been cooperating partners in a National Clearinghouse Program for the past sixteen years designed to facilitate the movement of blood and credit for the blood donations throughout the country, allowing a patient in one part of the country to receive credit for the voluntary donation of blood by a friend or relative in another part of the country; and

Whereas, the clearinghouse has a single mechanism for the national control of blood inventories, arranging interbank borrowing and lending of blood units and alleviating specific type shortages reported by banks in various parts of the country; and

Whereas, since its conception, the clearinghouse has handled the transfer of more than 4,000,000 blood replacement credits resulting in an estimated financial saving of approximately \$97,000,000 in blood costs for patients receiving blood transfusions, especially significant to families of chronic blood users (such as hemophiliacs) whose transfusion expenses are offset when blood is donated in their name; and

Whereas, the unilateral termination of the clearinghouse agreement by the American Red

Cross effective October 19, 1976, is destined to cause confusion among hospitals and a potential hardship to transfusion patients; now therefore be it

RESOLVED, that The Medical Society of New Jersey declares the withdrawal of the American National Red Cross from the National Clearinghouse Program is counter-productive and not in the public interest; and be it further

[RESOLVED, that The Medical Society of New Jersey supports the concept of a non-replacement or deposit fee as an effective incentive for blood replacement, and as a method of financial savings for patients when blood is replaced by relatives or friends; and be it further]

**Amended by the Reference Committee by deletion of the above (second) resolved (page Tr 140)**

RESOLVED, that The Medical Society of New Jersey call on the American Blood Commission and its organizational members to urge the leaders of the American National Red Cross to reconsider and support the National Blood Clearinghouse Program.

**Adopted as amended by the Reference Committee (page Tr 140)**

## #26 Air Pollution

From the Burlington County Medical Society

(Reference Committee "G")

Whereas, New Jersey residents have the distinction of being in one of the most polluted areas of the United States; and

Whereas, we strenuously protest that we are forced to inhale lethal elements in the air we breathe; and

Whereas, our high levels of air pollutants may be linked with our suffering unusually high incidences of cancer and cardiorespiratory

diseases; now therefore be it

RESOLVED, that it shall henceforth be a top priority of The Medical Society of New Jersey to (1) assay the extent of the problem; (2) take all effective measures to familiarize the public with the implications of this deplorable situation; and (3) to define and implement corrective measures.

Adopted (page Tr 140)

## #27 Sludge Pollution

From the Essex County Medical Society

(Reference Committee "G")

Whereas, the State of New Jersey has been known for its clear waters, clean beaches and excellent fisheries; and

Whereas, our bay and ocean waters have suffered from a tremendous influx of pollution in the past five years; and

Whereas, many professional divers have reported that the ocean floor off our coast is now desert, devoid of oxygen and consequently life; and

Whereas, this pollutant condition has disrupted and curtailed our clamming, oystering, lobstering, and fishing industries; and

Whereas, the problem of tides of dead algae threatens our bathing beaches and could affect the health of those who use our shores for business or recreation; and

Whereas, the present system of dumping of

sludge close to our beaches has now become a public health menace; now therefore be it

RESOLVED, that The Medical Society of New Jersey initiate action against the public health problem of pollution of our New Jersey waters; and be it further

RESOLVED, that we work toward legislation or regulations which quickly would move the present twelve mile sludge-dumping sites to 106 miles offshore until the year 1981, at which time all ocean dumping will be phased out; and be it further

RESOLVED, that The Medical Society of New Jersey send copies of this resolution to designated officials of the Environmental Protection Agency, the National Oceanic Atmospheric Agency and the Department of Environmental Protection as well as other concerned government officials.

Adopted (page Tr 140)

## #28

### Restricting the Use of Saccharin

From John Winslow, M.D., Delegate, Essex County

(Reference Committee "G")

Whereas, the artificial sweetener, saccharin, has been used extensively for over sixty years, with no discernible ill effects except a strong salivary taste over many hours if too large a dose is ingested; and

Whereas, the contemplated ban on saccharin is based on testing on a low form of animal, not necessarily related to man, except perhaps in behavior at times; and

Whereas, the rate of bladder cancer in the human being does not seem to be higher in diabetics who have taken saccharin for many years, but is probably rather related to the amount of cigarette smoking done by the afflicted; and

Whereas, the sugar refining interests have always looked for any cause to get rid of artificial sweetening competition, even though the

ill effects of large amounts of sugar ingestion in the way of dental ruination, onset of obesity and other ill effects, and the acceleration of diabetic onset, are well known, now therefore be it

RESOLVED, that The Medical Society of New Jersey officially deplore the contemplated ban by the Food and Drug Administration of the United States Government of the use of the artificial sweetener, saccharin, and that the Food and Drug Administration be required to present the case to an impartial panel of top medical scientists concerning this chemical and other chemicals, such as the cyclamates, which have been under scrutiny for possible adverse effects before any ban is contemplated and most certainly before it is put into effect.

Adopted (page Tr 140)

## #29

### Procedure in the House of Delegates

From the Mercer County Medical Society

(Reference Committee "H")

Whereas, there has been considerable confusion in the past with regard to casting votes based upon recommendations of reference committees; and

Whereas, clarification of the voting procedure would be expeditious; now therefore be it

RESOLVED, that when the House of Delegates meets as a body, considering a resolution, committee report, or must take action on any other specific issue, a "yes" vote by a delegate will constitute a vote for the proposition in question, and a "no" vote will be a vote against the proposition.

Adopted (page Tr 141)



## #30

### Tort Law

From the Union County Medical Society

(Reference Committee "E")

Whereas, the current crisis in professional liability and the imminent crisis in other fields such as product and auto liability are, in reality, a crisis in public policy; and

Whereas, the original tort law objective of restitution by a negligent person to another who has sustained a loss or injury has over the years changed to encompass two other factors: (1) punitive judgments with the intent to discipline, and (2) general compensation; and

Whereas, since the tort system has been perverted from its original primary objectives, changes in the system are imperative; now therefore be it

RESOLVED, that The Medical Society of New Jersey, in conjunction with other friendly interested parties [but excluding the Association of Trial Lawyers] petition and work with the State Legislature to (1) eliminate the disciplinary functions from the tort system and expand and improve other methods of discipline outside the tort system, and (2) provide for binding and contractual arbitration if defendant and plaintiff agree. (See the following.)

Amended by the Reference Committee by deletion of "but excluding the Association of Trial Lawyers," indicated by brackets in the above.

Adopted as amended by the Reference Committee (page Tr 136)

#### Addenda to Resolution #30

To bring about the desired effect of the above resolution, these specific changes in the law should be considered:

- 1) The fee of the plaintiff's attorney should bear a reasonable relation to the effort expended rather than be tied to the size of the award.
- 2) It should be incumbent upon the plaintiff's attorney to certify with reasonable exactitude the medical validity of a malpractice claim in order to reduce the institution of frivolous or nuisance suits.
- 3) "Compassionate" awards for pain and suffering, inconvenience and loss of consortium should be eliminated and the award based strictly on economic loss.
- 4) Peer review and licensure regulations should be improved and strictly enforced so that the negligent individual effectively is prevented from harming patients directly and his fellow practitioners indirectly.
- 5) Periodic payments for awards above \$30,000 rather than lump sum awards should be allowed. This should be coupled with a provision for the return of funds to prevent windfall benefits to persons other than the plaintiff.
- 6) Evidence of remarriage in wrongful death suits should be allowed to prevent unfair exploitation of such a situation.

House concurred in the decision of the Committee on Resolutions that Resolutions #31, #32, #33, and #34 were not acceptable as emergency resolutions.

## #35

# Endorsement of AMA National Health Insurance Proposal

From the Board of Trustees

(Reference Committee "A")

Whereas, the endorsement of specific legislation drafted by the AMA and introduced into the Congress as S. 218 and H.R. 1818—the Comprehensive Health Care Insurance Act of 1977—provides the most effective method of articulating AMA support of health insurance through the private sector in the formulation of a national health insurance policy by Congress; and

Whereas, the AMA proposal affords a viable solution to the problem of providing quality health and medical care to everyone at a cost the nation can afford; and

Whereas, the AMA approach would accomplish this goal with an absolute minimum of federal involvement in funding; and

Whereas, in poll after poll the public indicates that it overwhelmingly prefers a national health insurance program that is free of federal control; and

Whereas, the AMA proposal would preserve

the private sector thrust of medical and health care and its financing by building upon the highly successful existing system of private health insurance; and

Whereas, the AMA position maintains continued total opposition to nationalization of the medical profession and would honor the profession's wants and needs while preserving professional freedom; now therefore be it

RESOLVED, that The Medical Society of New Jersey believes that the 17 principles as enunciated by the AMA are essential in any form of national health insurance; and be it further

RESOLVED, that The Medical Society of New Jersey endorses the AMA's participation in the national health insurance debate and its support of health insurance through the private sector, through the introduction of S. 218 and H.R. 1818.

Adopted (page Tr 130)

House concurred in the decision of the Committee on Resolutions that Resolutions #36, #37, and #38 were not acceptable as emergency resolutions.

The following resolutions were presented from the floor under New Business:

## Dr. Martin Goldfield

RESOLVED, that the Secretary of The Medical Society of New Jersey be instructed to forward a communication to the press, the State Department of Health, and the Governor

of its confidence in the integrity and capability of Dr. Martin Goldfield.

**Adopted**

## Fiscal Notes on Resolutions and Reports

RESOLVED, that where possible the staff of The Medical Society of New Jersey provide a fiscal note on resolutions and/or reports that

may commit the Society to any expenditures. (This conforms with AMA protocol.)

**Adopted**

## Petition Legislature on Professional Liability Bills

Whereas, the Legislature of the State of New Jersey has had before it for over a year proposals addressing the issue of tort reform; and

Whereas, there has been sufficient time for the Legislature to give full and fair consideration and discussion to all issues attendant to these bills; now therefore be it

RESOLVED, that the House of Delegates of The Medical Society of New Jersey transmit to the Legislature its concern over this unnecessary

delay; and be it further

RESOLVED, that the Legislature be petitioned by this House of Delegates to act immediately, positively, and affirmatively on the "Garra-mone package"; and be it further

RESOLVED, that this petition of the Legislature be accompanied by appropriate press releases.

**Adopted**



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# REFERENCE COMMITTEES

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## Reference Committee on Constitution and Bylaws

Peter Beaugard, M.D., Chairman

Reference Committee on Constitution and Bylaws met on Saturday, May 14, 1977, with all members present: Doctors Donald Akey, Salvatore J. Angelo, Thaddeus A. Balinski, Samuel B. Pole, Edward A. Schauer (alternate), and the chairman. Approximately 20 delegates and members were present to discuss the various items under consideration.

### 1. Proposed Constitution of the Medical Society of New Jersey (page Tr 46)

The Committee **recommends** second year adoption of the proposed Constitution.

#### Adopted

### 2. Proposed Bylaws of the Medical Society of New Jersey (page Tr 47)

The Committee **recommends** adoption of the proposed Bylaws with the following amendments:

#### a. Chapter IV—Judicial Council, Item (d)—Duties of the Judicial Council (3) (page Tr 52)

The Committee **recommends** that paragraph #3 be eliminated, as it is unnecessary and possibly confusing. The paragraphs that follow will then be renumbered.

#### Adopted

The Committee further **recommends** that the new paragraph # 3 shall have the following sentence added after "appropriate county judicial committee" . . . "*The jurisdiction of the Judicial Council extends to all members in all categories of membership within the Medical Society of New Jersey.*"

#### Adopted

#### b. Chapter VI—Other Delegates and Representatives, Item (a) (page Tr 54)

The Committee **recommends** the addition of the following sentence after the words "ending on the second December 31 thereafter." "*A member may be elected to this office any number of times until he or she reaches age 65.*"

#### Adopted

The Committee feels that this revision will enable any qualified member of our Society to become active on the national level with the AMA. It is felt that limiting tenure to three (3) two-year terms makes reaching high-level AMA positions virtually impossible.

If the above recommendation is adopted, this would automatically cancel out the third sentence under Item (a), page Tr 54, and the Committee **recommends** its deletion.

#### Adopted

#### c. Chapter X—Finance, Section 1—Annual Assessment (page Tr 59)

The Committee **recommends** that the word "*Dues*" be placed in parentheses following the title of the Section, making it read "*Section 1—Annual Assessment (Dues).*"

#### Adopted

#### d. Chapter X—Finance, Section 1—Annual Assessment, subparagraph (e) (2) (page Tr 59)

The Committee **recommends** that this sentence be reworded to read "he is serving as a draftee with the armed forces of the United States."

#### Not adopted

- e. **Chapter XI—Component Societies—Section 2—Qualification of Members, Item (b), subparagraph (1)** (Page Tr 60)

The Committee **recommends** that this subparagraph be reworded to read as follows: "*hold a degree in medicine or osteopathy acceptable to this Society*," eliminating the phrase "*obtained from a professional school approved by this Society at the time of his graduation*."

**Not adopted**

**By action of the House paragraph (1), item (b) of Section 2—Qualification of Members, Chapter XI of the Bylaws was deleted.**

In addition, during the discussion two items received enough attention that we feel they should be referred to the Committee on Revision of Constitution and Bylaws for consideration. These were the advisability of a probationary period for new members and some category of membership for medical students.

**Bylaws adopted as amended by the Reference Committee and the House.**

I wish to thank my committee for their able assistance in our deliberations and those members of the Society who took part in our discussions.

## Reference Committee "A"

Frank Y. Watson, M.D., Chairman

Reference Committee "A" met on Saturday, May 14, 1977, with all members present: Doctors Herbert M. Epstein, Howard Lehr, Thomas E. Mattingly, Jr., Frank Wolf, Frank Malta (alternate) and the chairman. Approximately 50 delegates and members were present to discuss the various items under consideration.

1. **President** (page Tr 5)

The Committee **recommends** that the report be filed and that commendation and special thanks be extended to Dr. John S. Madara.

**Adopted**

2. **Board of Trustees** (page Tr 18)

The introductory portion of this report, covering the general activities of the Board, was reviewed and approved.

The Committee **recommends** that the report be filed.

**Adopted**

a. **Admission of Osteopathic Physicians to the Medical Society of New Jersey** (page Tr 18)

The Committee **recommends** that the report be filed.

**Adopted**

b. **AMA Membership Drive** (page Tr 19)

The Committee **recommends** that the report be filed.

**Adopted**

c. **Assurance of Professional Competence** (page Tr 19)

The Committee **recommends** that the report be filed.

**Adopted**

d. **Chiropractors Requesting Radiological Examinations** (page Tr 20)

The Committee **recommends** that the report be

filed.

**Adopted**

- e. **Intern and Resident Committees** (page Tr 20)

The Committee **recommends** that the report be filed.

**Adopted**

- f. **Procedural Guidelines for Health Facilities Dealing with Comatose Patients** (page Tr 20)

The Committee **recommends** that the report be filed.

**Adopted**

3. **Secretary** (page Tr 9)

The Committee **recommends** that the report be filed.

**Adopted**

4. **Judicial Council** (page Tr 26) and Supplemental (page Tr 27)

The Committee **recommends** that the report be filed.

**Adopted**

5. **Executive Director** (page Tr 28)

The Committee **recommends** that the report be filed.

**Adopted**

6. **Credentials** (page Tr 31)

The Committee **recommends** that the report be filed.

**Adopted**

7. **Special Committee on Long Range Planning and Development** (page Tr 81)

The Committee **recommends** that the report be filed.

**Adopted**

**8. Resolutions:**

- a. **Proportional Representation at the Annual Meeting—Resolution #1** (page Tr 105)

The Committee **recommends** that Resolution #1 be rejected because it violates the principle embodied in the Bylaws of the Medical Society of New Jersey that each component society shall select from among its membership whom-ever it wishes to represent it in the House of Delegates, so long as the number selected does not exceed the number provided for in the By-laws. The Committee feels that if a component society wishes its President and President-Elect to be Delegates it can so provide in its bylaws or by the simple expedient of electing as President and President-Elect only persons who are Delegates.

**Adopted**

- b. **Apportionment of AMA Delegates and Alternates—Resolution #2** (page Tr 105)

The Committee **recommends** that Resolution #2 be rejected because the present method of AMA Delegate and Alternate Delegate selection functions in the best interest of the Society by permitting the selection of the most qualified persons in the Society to represent it in the AMA, rather than mandating a certain number of persons from specified geographic areas whether or not the persons are the most qualified.

**Adopted**

- c. **Establishment of Compulsory Membership in the AMA—Resolution #3** (page Tr 106)

Of all the matters to come before this Committee, this issue was debated the longest and with the greatest intensity by very articulate members of our Society; the Committee wishes to thank them for their efforts. The Committee urges all physicians to join the AMA and



strongly support its activities because the Committee believes that the larger the membership of the AMA, both in total number and total percentage of physicians, the better the AMA will be able to serve the American medical profession and the patients it serves. The Committee, however, is not convinced that mandating membership is the most desirable way to maximize the membership of the AMA.

The Committee therefore **recommends** that Resolution #3 be rejected.

**Adopted**

- d. **Endorsement of AMA National Health Insurance Proposal**—Resolution #35 (page

Tr 125)

The whereases in the Resolution and the testimony before the Committee convinced it that the AMA has taken a progressive and realistic position based on sound principles in its proposed Comprehensive Health Care Insurance Act of 1977 and therefore merits the endorsement and support of the Medical Society of New Jersey as it represents the medical profession through its active participation in the debate on national health insurance.

The Committee therefore **recommends** that Resolution #35 be adopted.

**Adopted**

## Reference Committee "B"

Edward M. Coe, M.D., Chairman

Reference Committee "B" met on Saturday, May 14, 1977, with the following members present: Doctors Francis A. Pflum, Donald A. McLean, and the chairman. Approximately 32 delegates and members were present to discuss the various items under consideration.

1. **Treasurer** (page Tr 10)

The Committee **recommends** that the report be filed.

**Adopted**

2. **Finance and Budget** (page Tr 31)

The Committee **recommends** that the recommendations on page Tr 33 and Tr 34 be approved.

**Adopted**

The Committee **recommends** that the report be filed, with special notation to the House of Delegates of the increase in the budget of Item

C-4 (Public Relations) on page Tr 34.

**Adopted**

It is the **recommendation** of the Reference Committee that the annual reports of the Treasurer and the Committee on Finance and Budget be mailed to the delegates with the other annual reports prior to the Annual Meeting when technically feasible.

**Adopted**

3. **Medical Student Loan Fund** (page Tr 41)

The Committee **recommends** that the recommendations on page Tr 45 of the annual report be approved.

**Adopted**

The Committee **recommends** that the report be filed.

**Adopted**

#### 4. Physicians' Relief Fund (page Tr 85)

The Committee **recommends** that the recommendations on page Tr 86 of the annual report be approved, with the exception of recommendation (a). The Committee on Finance and Budget reported that "No allocation is provided for the Committee on Physicians' Relief Fund for 1977-78. Based on an audit by IRS, the Physicians' Relief Fund has been found to be in violation of the 501-(C)-(6) Non-Profit status MSNJ has held over the years."

The Committee **recommends** that the report be filed.

#### **Adopted**

#### 5. Publication (page Tr 45)

The Committee **recommends** that the report be filed.

#### **Adopted**

#### 6. Resolutions:

- a. **Definition of Professional Liability Assessment**—Resolution #5 (page Tr 106)
- b. **Professional Liability Assessment**—Resolution #6 (page Tr 107)
- c. **Professional Liability Assessment**—Resolution #7 (page Tr 107)
- d. **The Medical Society of New Jersey Professional Liability Assessment**—Resolution #8 (page Tr 108)
- e. **Elimination of Two-Hundred Dollar Assessment on New Members of the Medical Society of New Jersey**—Resolution #9 (page Tr 108)
- f. **Exemption from Professional Liability Assessment**—Resolution #10 (page Tr 109)
- g. **Exemption from Professional Liability Assessment**—Resolution #11 (page Tr 109)

Resolutions #5 through #11 are related to the professional liability assessment. All resolutions were discussed individually and as a whole. The intent of all has been embodied in Resolution #5 as amended by the Reference Committee as follows:

*RESOLVED, that all regular dues-paying members shall be expected to honor the professional liability assessment, except as otherwise determined by the Executive Committee when considering individual requests for exemption as provided in MSNJ's Bylaws; and be it further*

*RESOLVED, that the mandatory assessment be discontinued for new members as of December 31, 1977; and be it further*

*RESOLVED, that the Medical Society of New Jersey continue billing those physicians who have not paid the \$200 assessment until such billings become unprofitable.*

---

Resolution #5 was further amended by the House by changing the date in the second Resolved to May 16, 1977 and deleting the words "until such billings become unprofitable" in the third Resolved to read:

**RESOLVED, that all regular dues-paying members shall be expected to honor the professional liability assessment, except as otherwise determined by the Executive Committee when considering individual requests for exemption as provided in MSNJ's Bylaws; and be it further**

**RESOLVED, that the mandatory assessment be discontinued for new members as of May 16, 1977 and be it further**

**RESOLVED, that The Medical Society of New Jersey continue billing those physicians who have not paid the \$200 assessment.**

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#### **Point of Information**

**Bylaws, Chapter X—Finance, Section 1—Annual Assessment**

- e. This assessment shall not be levied against any member in good standing if:

- (1) he shall have attained the age of seventy (70) years; or
- (2) he is serving with the armed forces of the United States; or
- (3) he is a member emeritus; or
- (4) the payment of the assessment would be a financial hardship by reason of physical dis-

ability or illness. A member may also be excused from payment of the assessment because of financial hardship for other reasons, but these reasons must be set forth annually by the secretary of the member's component society.

The Committee **recommends** that Resolution #5 be adopted as amended.

**Adopted as amended by the Reference Committee and the House.**

## Reference Committee "C"

John Van Mater, M.D., Chairman

Reference Committee "C" met on Sunday, May 15, 1977, with the following members present: Doctors David L. Broadnax, Frank M. Galioto, Gastone A. Milano (alternate), Gabor Somjen (alternate), and the chairman. Approximately 81 delegates and members were present to discuss the various items under consideration.

### 1. Board of Trustees

#### a. Ad Hoc Committee on Professional Liability (page Tr 20) and Supplemental #1 (Tr 24)

The Committee **recommends** that on page (Tr 25) of Supplemental #1, recommendation (1) be amended to read as follows:

*That the \$200 mandatory assessment continue in effect for all members of the Society, as well as new members of the Society, but that the payment of this assessment be demanded by December 31, 1977.*

**No action necessary because of adoption of Resolution #5 as amended.**

The Committee **recommends** that recommendation (2) on page (Tr 25) of Supplemental #1 be approved.

**Adopted**

The Committee **recommends** that the report be filed.

**Adopted**

#### b. Assignment of Benefits (page Tr 21)

The Committee **recommends** that the report be filed.

**Adopted**

#### c. Blue Shield Claim Form (page Tr 21)

The Committee **recommends** that the report be filed.

**Adopted**

#### d. Expulsion of Unqualified Physicians Testifying As Expert Witnesses (page Tr 22)

The Committee finds the language to be ambiguous and the word "expulsion" is not defined.

The Committee **recommends** that the report be filed.

**By action of the House the report referred to in item 1(d) was endorsed and sent to MSNJ's AMA Delegates for action.**



e. **OCHAMPUS** (page Tr 22)

The Committee **recommends** that the report be filed.

**Adopted**

2. **Medical Inter-Insurance Exchange of New Jersey** (page Tr 97)

The Committee **recommends** that the report be filed.

**Adopted**

3. **Medical-Surgical Plan of New Jersey** (page Tr 91)

The Committee **recommends** that the report be filed.

**Adopted**

4. **Medical Defense and Insurance** (page Tr 36)

The Committee **recommends** that the recommendation contained in the report be approved and the balance of the report be filed with commendation to the Chairman.

**Adopted**

5. **Retirement Plan for Physicians** (page Tr 86)

The Committee **recommends** that the report be filed with commendation to the Chairman.

**Adopted**

6. **Resolutions:**

a. **Commissions Re Professional Liability—**  
Resolution #12 (page Tr 110)

The Committee feels that Resolution #12 is argumentative and would serve no purpose.

The Committee **recommends** that Resolution #12 be rejected.

**Adopted**

b. **Legislation Concerning Professional Liability**  
— Resolution #13 (page Tr 114)

The Committee **recommends** that Resolution #13 be rejected and referred to the Council on Legislation for informational purposes.

**Adopted**

c. **Assignment of Benefits by Blue Shield—**  
Resolution #14 (page Tr 114)

The Committee finds Resolution #14 to be a disservice to participating physicians of Blue Shield.

The Committee **recommends** that Resolution #14 be rejected.

**Adopted**

d. **Acceptance of Standard Claim Forms—**  
Resolution #15 (page Tr 115)

The Committee **recommends** that Resolution #15 be referred to the Council on Medical Services.

**Adopted**

e. **Increase Rider J Coverage for Pathological Laboratory Services—** Resolution #16 (page Tr 115)

The Committee feels that there should be a program of information to employers and employees concerning the availability of various Rider J contracts and, therefore, the Committee **recommends** that Resolution #16 be rejected.

**Adopted**

f. **Joining the Medical Inter-Insurance Exchange—** Resolution #17 (page Tr 116)

The Committee **recommends** that the first and second "resolveds" be amended to read as follows:

*RESOLVED, that the Medical Society of New*

*Jersey urge the Board of Directors of the MIIE to determine that physicians joining the MIIE prior to January 1, 1979, shall be considered charter members; and be it further*

*RESOLVED, that anyone joining the MIIE after the above date shall be required to pay an additional surcharge.*

**Upon action by the House Resolution #17, the Reference Committee's proposed amended "resolveds," and a further proposed amended "resolved" (see below) offered from the floor were referred to the Board of Trustees.**

*Proposed amendment from the floor.*

That the Medical Society of New Jersey and the Board of Directors of the Medical Inter-Insurance Exchange do all in their power to get the acceptance of the Insurance Commissioner of New Jersey of a plan whereby there would be a certain percentage reduction in the yearly premium payment for those

physicians in the MIIE plan who are members of the Medical Society of New Jersey or the New Jersey Association of Osteopathic Physicians and Surgeons.

**g. Physicians Starting Practice in New Jersey**  
— Resolution #18 (page Tr 116)

The Committee **recommends** that the "resolved" portion of Resolution #18 be amended to read as follows:

*RESOLVED, that The Medical Society of New Jersey investigate ways that a fund could be established to loan the first year's premiums and surplus capitalization monies to all needy physicians who are about to establish a practice of medicine or surgery in New Jersey to be paid back over a period of three (3) years at minimal interest.*

**By action of the House Resolution #18 and the Reference Committee's amended "resolved" were referred to the Board of Trustees.**

## Reference Committee "D"

Gerald H. Rozan, M.D., Chairman

Reference Committee "D" met on Saturday, May 14, 1977, with the following members present: Doctors Alfonse A. Cinotti, Francis X. Keeley, Frederick C. Steller, and the chairman. Approximately 30 delegates and members were present to discuss the various items under consideration.

### 1. Board of Trustees

#### **High Fees for Participation in Continuing Medical Education (page Tr 22)**

It was noted that the Committee on Medical Education of the Medical Society of New Jersey will serve as a conduit and reports of exorbitant fees should be transmitted by members to the Society for investigation.

The Committee **recommends** that the report be filed.

### **Adopted**

#### **2. Medical Education (page Tr 40)**

The Committee noted that the Board of Trustees had met on May 13, 1977 and decided that the Society would send certified letters to 1,785 members for whom there is no record of meeting the continuing medical education requirement. The letter is intended to ask the delinquent member what he intends to do about his nonfulfillment of that requirement and further, to make him aware that he is placing his membership in the Society in jeopardy. The Reference Committee would like to make

clear, however, that the comments of members present would lead us to believe there may be, in fact, far fewer than 1,785 members who have not fulfilled their requirement because of difficulties that the AMA has experienced with its computer program in sending correct information to our Society.

The Committee **recommends** that the report be filed with commendation to the Chairman and the members of the Committee.

#### **Adopted**

### **3. Emergency Medical Care (page Tr 79)**

The Committee **recommends** that the report be filed.

#### **Adopted**

### **4. Medicine and Religion (page Tr 84)**

The Committee **recommends** that the report be filed.

#### **Adopted**

### **5. Resolution:**

#### **Continuing Medical Education—Resolution #19 (page Tr 117)**

In the third "Whereas" there appears to be an inaccuracy in that it is not true that \$25,000 is appropriated to the Academy of Medicine of New Jersey for the purpose of accrediting programs. The \$25,000 is given to the Academy of Medicine actually to conduct programs for the physicians of the State. It has been estimated that if the Medical Society of New Jersey attempted this project on its own, the cost would be over \$100,000.

The Committee feels quite strongly that the problem raised in this Resolution has already been addressed by the Academy and a county medical society can now get approval from the Academy within thirty (30) days or less in special circumstances.

The Committee **recommends** that Resolution #19 be rejected.

#### **Adopted**

## **Reference Committee "E"**

Benjamin Wolfson, M.D., Chairman

Reference Committee "E" met on Sunday, May 15, 1977, with all members present: Doctors John P. Kengeter, Alexander D. Kovacs, Nicholas E. Marchione, Kenneth A. Morrissey, and the chairman. Approximately thirty-one delegates and members were present to discuss the various items under consideration.

### **1. Legislation (page Tr 63) and Supplemental (Tr 65)**

It was felt that State legislative committees frequently are not provided sufficient and

accurate information from physicians which could influence pending legislation in a more favorable way. Testimony given during the Reference Committee meeting indicated a disconcerting absence of physicians at legislative hearings. It is **recommended** that more effective leadership be established by promoting attendance at such hearings of informed members of the Society.

The Committee **recommends** that the report and the supplemental be filed.

#### **Adopted**



## 2. Public Relations (page Tr 77)

Several members present expressed grave concern over the quality and content of the Society's public relations program. A representative from the Society's public relations firm was present and helped explain the approach used in the advertising. Recommendations were made to him by Society members present.

The Committee **recommends** that the report be filed.

**Adopted**

## 3. Resolutions:

### a. Hospital Autopsies—Resolution #20 (page Tr 118)

While the Committee recognizes the need for autopsy information to advance medical knowledge, it believes that this Resolution represents an intrusion into an area which is of great personal significance. The Committee deems privacy and individual rights to be

paramount to the benefits to be derived from mandatory autopsies.

The Committee **recommends** that Resolution #20 be rejected.

**Adopted**

### b. Tort Law—Resolution #30 (Tr 124)

The Committee took note of the action of the AMA House of Delegates in which changes in tort laws have been recommended. The Committee believes that the intent of this Resolution is pertinent.

The Committee **recommends** that the "Resolved" portion of Resolution #30 be amended by deleting from line 16 and 17 the words "*but excluding the Association of Trial Lawyers.*"

**Adopted**

The Committee **recommends** that Resolution #30 be adopted as amended.

**Adopted**

## Reference Committee "F"

William M. Chase, M.D., Chairman

Reference Committee "F" met on Sunday, May 15, 1977, with the following members present: Doctors Harry H. Brunt, Jr., Ernest S. Redfield, Robert A. Weinstein, Carl A. Restivo, (alternate), and the chairman. Approximately 38 delegates and members were present to discuss the various items under consideration.

### 1. Board of Trustees

#### a. CAT Scanners (page Tr 23)

There was considerable discussion relating to the concern about requiring certificates of need for individuals or groups of physicians. Nevertheless, the general consensus was that the

Committee recommend that the report be filed and that the individual physician's concerns be noted.

The Committee **recommends** that the report be filed.

**Adopted**

#### b. Medical Assistance Advisory Council (page Tr 23)

There was considerable discussion with respect to the actions of the Medical Assistance Advisory Council and full support of the Board of Trustees' approval of the resolution petitioning

the Legislature of the State of New Jersey to restore adequate fees for the Medicaid providers. However, those present voiced their desire to be able to communicate with the Medical Assistance Advisory Council through the Committee on Medicaid in order to guarantee that their concerns are conveyed to the involved agency.

The Committee **recommends** that the report be filed.

**Adopted**

c. **Relative Value Index** (page Tr 23)

There was an airing of feelings with respect to the Relative Value Index and it was clarified as to its relationship with the Federal Trade Commission constraints.

The Committee **recommends** that the report be filed.

**Adopted**

2. **Medical Services** (page Tr 70)

The information discussed in this report was aired in general fashion, item by item. Dr. Victor Boogdanian was present to give the benefit of his knowledge as a member of the Council on Medical Services.

The Committee **recommends** that the report be filed.

**Adopted**

3. **Occupational Health, Workmen's Compensation, and Rehabilitation** (page Tr 71)

The Committee **recommends** that the report be filed.

**Adopted**

4. **Medicaid** (page Tr 83)

Dr. Harvey J. Shwed was present to discuss the interrelationship between the Committee on Medicaid and its interaction with Mr. Gerald Reilly of the New Jersey Department of Human

Services and, although he was not present at the outset of the Reference Committee meeting, he noted the successful lines of communication between the Medicaid Committee and the State agency. Dr. James Gardam further complimented Dr. Shwed and his Committee by recalling Mr. Reilly's statement of May 14, 1977, (at the Governor's Conference) which expressed Mr. Reilly's pleasant surprise at the completely open and honest communication between the Committee and his Agency. Mr. Reilly had noted that it was a learning experience for himself and proved a fertile ground for ironing out hostile difficulties and emotional problems.

The Committee **recommends** that the report be filed.

**Adopted**

5. **Membership Inquiries and Complaint Committees** (page Tr 85)

The Committee **recommends** that the report be filed.

**Adopted—Reference Committee suggested that availability of Committees be called to attention of membership.**

6. **Mental Health** (page Tr 72)

Dr. Robert Garber was not present to discuss the content of his report. Nevertheless, Dr. Shwed, Dr. Friedland and others, including Dr. Brunt, were present to discuss the impact of Senate Bill 1677 on the practicing physician with respect to the privilege of commitment, on an involuntary basis, of patients to psychiatric facilities. The chief area of controversy seemed to stem from the exclusion of family physicians and other nonpsychiatric specialists from participating in this process. It appears that the most recent information is that there has been an effective change to permit others in the medical profession in addition to those recommended (psychiatrists and psychologists) to admit such patients.

The Committee **recommends** that the report be filed.

**Adopted**

## 7. Resolutions:

### a. Reporting of Medicaid/Medicare Fees— Resolution #21 (page Tr 119)

After considerable discussion and without the benefit of the writer of this Resolution, it was the final consensus that this Resolution was written poorly and upon polling representatives from Mercer County and with the help of Dr. Shwed, because of his expertise on the Committee on Medicaid, the following substitute Resolution is **recommended**:

*Whereas, the reporting of physician's Medicaid and Medicare reimbursed fees has been widely publicized in the news media; and*

*Whereas, this reporting has been manifestly inaccurate, frequently confusing amounts paid to groups with amounts paid to individuals; and*

*Whereas, this type of disclosure is frequently inaccurate and susceptible to gross distortions and inflammatory innuendo, casting aspersions by the media and the public concerning the vast majority of honest and ethical physicians; now therefore be it*

*RESOLVED, that the House of Delegates of the Medical Society of New Jersey oppose the indiscriminate release of such gratuitous information unless it has relevance to a specific allegation of abuse, fraud, or unethical practice, and be it further*

*RESOLVED, that the Board of Trustees and our AMA Delegates take steps to express our concern about this action.*

The Committee **recommends** that the Substitute Resolution be adopted.

**Adopted**

### b. Certain Changes to Cut Costs of Medicaid— Resolution #22 (page Tr 119)

After lengthy discussion with respect to the

contents of this Resolution and upon receiving clarification regarding the levels of care provided in nursing homes and with the additional contribution of Dr. Gardam with respect to the participation of young physicians, retired physicians, and handicapped physicians and their care for patients in nursing home facilities, it was felt that this Resolution was not in the best interest of the Society or the individual physician.

The author, Dr. John Winslow, therefore withdrew Resolution #22.

**The House agreed to withdrawal of Resolution #22.**

### c. National Catastrophic Health Insurance Plan—Resolution #23 (page Tr 119)

After considerable discussion and explanations of the feelings of most of the participants in this meeting, the Committee felt that this Resolution should be supported.

The Committee **recommends** that Resolution #23 be adopted.

**Not Adopted—Resolution #23 was rejected by the House.**

### d. Generic Drug Prescribing and Substitution— Resolution #24 (page Tr 120)

This Resolution was discussed by Dr. John Winslow, Essex County Medical Society, author. Upon receipt of a message from Dr. Gustav Ibranyi, Essex County Medical Society, who was responsible for Resolution #20, which was adopted by the 1974 House of Delegates, the Committee felt that the Resolution introduced this year by Dr. Winslow, although its intent was supportive, needed clarification as to how that support would be effected.

The Committee **recommends** that Resolution #24 be rejected and further **recommends** the continued support of Resolution #20 approved by the 1974 MSNJ House of Delegates.

**Adopted**



## Reference Committee "G"

Edwin W. Messey, M.D. Chairman

Reference Committee "G" met on Saturday, May 14, 1977, with all members present: Doctors Ralph J. Fioretti, Palma E. Formica, Donald J. Holtzman, Roger C. Laauwe, Jose A. de Castro, (alternate), and the chairman. Approximately 35 delegates and members were present to discuss the various items under consideration.

### 1. Board of Trustees

#### Ad Hoc Committee on Blood Procurement (page Tr 23)

The Reference Committee recognizes that blood procurement is a broad and complex problem which cannot be solved by our Society alone. The Committee feels that there were good points in suggested alternatives 1 and 3, and both should be considered. The present system is working but needs improvement, and our Society's input in the form of an ongoing Committee on Blood Procurement would be beneficial in lending advice, support, and prestige.

With this recommendation the Committee **recommends** that the report be filed.

**Adopted**

### 2. Chronically Ill and Aging (page Tr 79)

With no formal meetings and no formal report, the Reference Committee had nothing to consider from this committee.

### 3. Public Health (page Tr 73)

The Committee **recommends** that the report be filed.

**Adopted**

### 4. Cancer Control (page Tr 73)

The Committee **recommends** that the report be filed.

**Adopted**

### 5. Child Health (page Tr 74)

The Committee **recommends** that the report be filed.

**Adopted**

### 6. Conservation of Hearing and Speech (page Tr 74)

The Committee **recommends** that the report be filed.

**Adopted**

### 7. Conservation of Vision (page Tr 75)

The Committee **recommends** that the report be filed.

**Adopted**

### 8. Environmental Health (page Tr 75)

The Committee **recommends** that the report be filed.

**Adopted**

### 9. Maternal and Infant Welfare (page Tr 76)

The Committee **recommends** that the report be filed.

**Adopted**

10. **Ad Hoc Committee on Atomic Energy Plants and Minority Report** (pages Tr 88 and Tr 90)

The Committee **recommends** that the reports be filed.

**Adopted**

11. **Resolutions:**

a. **Blood Replacement**—Resolution #25 (page Tr 121)

After much debate, the audience appeared to be divided evenly on the Resolution. The Committee **recommends** that the first and third "Resolved" should remain, but the second "Resolved" is too restrictive. The Committee therefore **recommends** that the second "Resolved" be deleted and that the Resolution as amended be adopted.

**Adopted**

b. **Air Pollution**—Resolution #26 (page Tr 122)

The Committee **recommends** that Resolution #26 be adopted.

**Adopted**

c. **Sludge Pollution**—Resolution #27 (page Tr 122)

The Committee **recommends** that Resolution #27 be adopted.

**Adopted**

d. **Restricting the Use of Saccharin**—Resolution #28 (page Tr 123)

The Committee **recommends** that Resolution #28 be adopted.

**Adopted**

## Reference Committee "H"

Harry W. Fullerton, Jr., M.D., Chairman

Reference Committee "H" met on Sunday, May 15, 1977, with all members present: Doctor Aldo G. Baldi, Leticia de Castro, Frank R. Schell, James H. Spillane, John A. Surmonte (alternate), and the chairman. Approximately 15 delegates and members were present to discuss the various items under consideration.

1. **Annual Meeting** (page Tr 29)

Doctor Gardam, Chairman of the Committee on Annual Meeting, enlightened the Committee and those present as to the problems facing his

Committee in selecting the site for the 1978 Annual Meeting.

The Committee **recommends** that the report be filed and that the recommendations on page Tr 29 be approved.

**Adopted**

**Upon motion from the floor it was directed that information obtained by the Annual Meeting Committee concerning the time and site of the 1978 annual meeting be referred to the Board of Trustees for evaluation.**

2. **Scientific Program** (page Tr 30)

The Committee **recommends** that the report be filed.

**Adopted**

3. **Honorary Membership** (page Tr 30)

The Committee **recommends** that the report be filed.

**Adopted**

4. **The Medical Society of New Jersey Auxiliary Advisory** (page Tr 62)

The Committee **recommends** that the report be filed.

**Adopted**

5. **Nominations for Emeritus Membership** (page Tr 98) Supplementals #1, #2, and #3 (pages Tr 99)

The Committee **recommends** that the nominations be approved.

**Adopted**

6. **Resolution:**

**Procedure in the House of Delegates—Resolution #29** (page Tr 123)

The Committee **recommends** that Resolution #29 be adopted.

**Adopted**



# Report of the Nominating Committee and Election

James A. Rogers, M.D., Chairman

Office	Term	Nominee and County
President-Elect	1 year	Charles S. Krueger, M.D., Burlington
1st Vice-President	1 year	Alfred A. Alessi, M.D., Bergen
2nd Vice-President	1 year	George L. Benz, M.D., Essex
Secretary	3 years	Arthur Bernstein, M.D., Essex
Treasurer	3 years	Rudolph C. Gering, M.D., Mercer
Trustees		
1st District	3 years	*Frank Y. Watson, M.D., Essex
2nd District	3 years	James S. Todd, M.D., Bergen
4th District	1 year	S. Thomas Carter Jr., M.D., Camden
5th District	3 years	Sherman Garrison, M.D., Cumberland
Judicial Councilors		
2nd District	3 years	John I. Olpp, M.D., Bergen
5th District	3 years	John A. Surmonte, M.D., Salem
AMA Delegates		
	2 years	William J. D'Elia, M.D., Monmouth
	2 years	James S. Todd, M.D., Bergen
AMA Alternate Delegates		
	2 years	Alfred A. Alessi, M.D., Bergen
	2 years	Charles L. Cunniff, M.D., Hudson
	2 years	Frederick W. Durham, M.D., Camden
	2 years	Howard D. Slobodien, M.D., Middlesex
Delegates and Alternate Delegates to Other States		
New York		
Delegate	1 year	Albert E. Moriconi, M.D., Mercer
Alternate	1 year	E. Sterling Brown, M.D., Atlantic
Connecticut		
Delegate	1 year	Edward G. Bourns, M.D., Union
Alternate	1 year	Gastone A. Milano, M.D., Atlantic
Administrative Councils		
Legislation		
1st District	3 years	John R. Tobey, M.D., Essex
4th District	3 years	Meyer I. Abrams, M.D., Burlington
Medical Services		
1st District	3 years	Richard H. Sharrett, M.D., Union
4th District	3 years	Charles O. Tyler, M.D., Camden
Mental Health		
1st District	3 years	Alvin Friedland, M.D., Essex
2nd District	3 years	Ralph J. Fioretti, M.D., Bergen
Public Health		
1st District	3 years	Edward M. Coe, M.D., Union
4th District	3 years	Watson E. Neiman, M.D., Burlington
Public Relations		
1st District	3 years	Frank Y. Watson, M.D., Essex
4th District	3 years	Jesse Schulman, M.D., Ocean
Standing Committees		
Annual Meeting	3 years	James H. Spillane, M.D., Warren
Finance and Budget	3 years	Charles S. Krueger, M.D., Burlington
Medical Defense and Insurance	3 years	Frank J. Malta, M.D., Ocean
Medical Education	3 years	Arthur Bernstein, M.D., Essex
Publication	3 years	Julio del Castillo, M.D., Mercer
Auxiliary Advisory	3 years	Frederick W. Durham, M.D., Camden

\* Nominated and elected from the floor

consider the effect on  
coexisting diabetes when  
you prescribe a vasodilator\*



(POSTERIOR VIEW OF PANCREAS)

no interference in the management of the  
diabetic patient has been reported with

# VASODILAN<sup>®</sup>

(ISOXSUPRINE HCl)

TABLETS, 20 mg.

the compatible vasodilator

**\*Indications:** Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, the FDA has classified the indications as follows:

Possibly Effective:

1. For the relief of symptoms associated with cerebral vascular insufficiency.
2. In peripheral vascular disease of arteriosclerosis obliterans, thromboangiitis obliterans (Buerger's Disease) and Raynaud's disease.
3. Threatened abortion.

Final classification of the less-than-effective indications requires further investigation.

**Composition:** Vasodilan tablets, isoxsuprine HCl, 10 mg. and 20 mg.

**Dosage and Administration:** 10 to 20 mg. three or four times daily.

**Contraindications and Cautions:** There are no known contraindications to oral use when administered in recommended doses. Should not be given immediately postpartum or in the presence of arterial bleeding.

**Adverse Reactions:** On rare occasions, oral administration of the drug has been associated in time with the occurrence of severe rash. When rash appears, the drug should be discontinued. Occasional overdosage effects such as transient palpitation or dizziness are usually controlled by reducing the dose.

**Supplied:** Tablets, 10 mg.—bottles of 100, 1000, 5000 and Unit Dose; 20 mg.—bottles of 100, 500, 1000, 5000 and Unit Dose.

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MJL 54117

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# ATTENDANCE

## Official Attendance Report

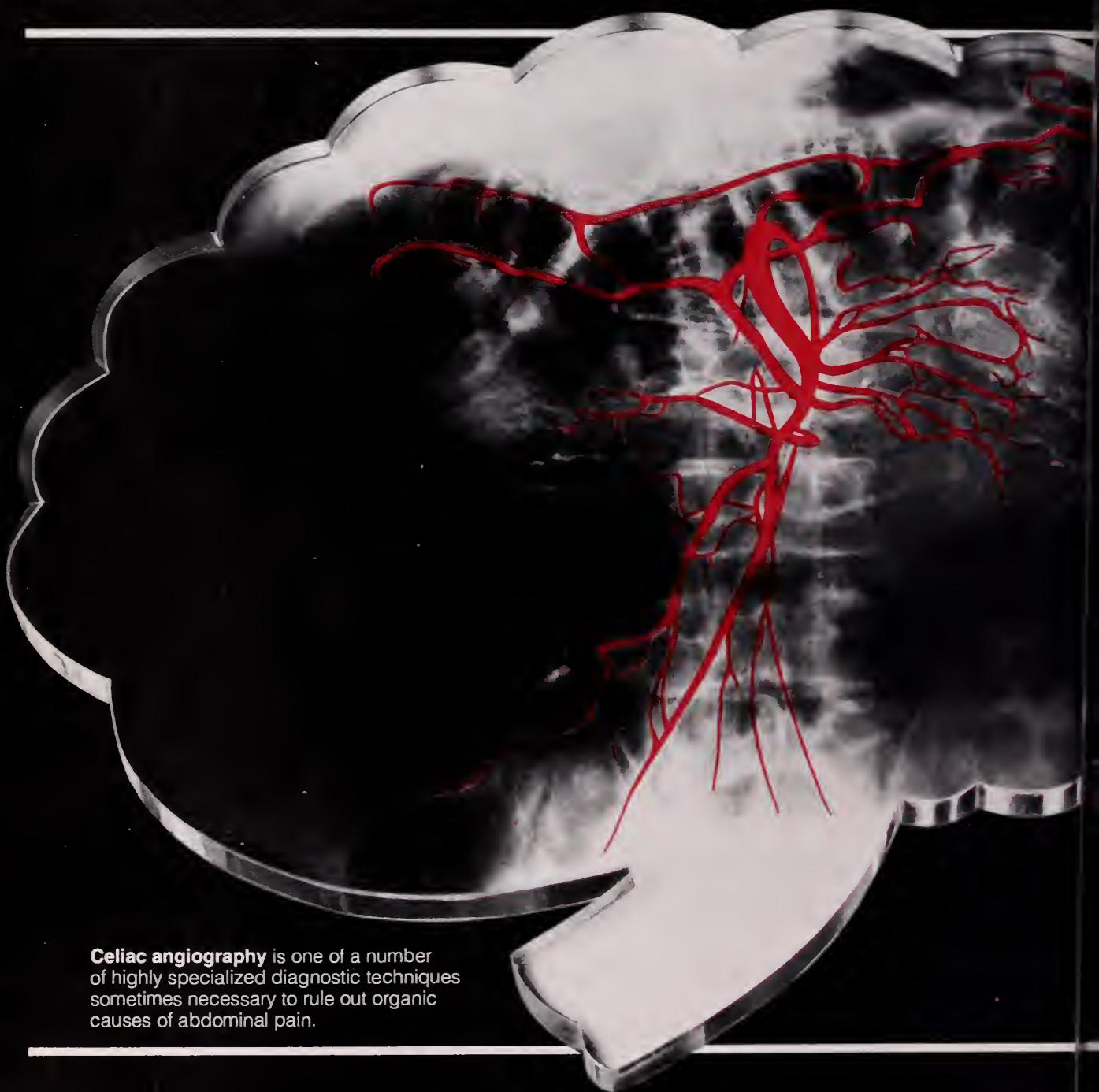
County	Delegates	Members	Total
Atlantic	10	54	64
Bergen	39	46	85
Burlington	11	26	37
Camden	23	62	85
Cape May	3	3	6
Cumberland	6	14	20
Essex	67	112	179
Gloucester	5	11	16
Hudson	24	30	54
Hunterdon	3	2	5
Mercer	25	56	81
Middlesex	23	40	63
Monmouth	21	45	66
Morris	19	28	47
Ocean	10	22	32
Passaic	29	35	64
Salem	3	6	9
Somerset	6	12	18
Sussex	3	2	5
Union	33	45	78
Warren	2	5	7
Fellows and Officers	23	—	23
	<u>388</u>	<u>656</u>	<u>1,044</u>
Physician Guests			50
Physician Exhibitors			21
<b>TOTAL PHYSICIAN REGISTRATION</b>			<u>1,115</u>
Auxiliary			337
Visitors			544
Exhibitors			244
<b>TOTAL REGISTRATION</b>			<u>2,241</u>

## FIVE-YEAR COMPARATIVE REGISTRATION FIGURES

Year	Physicians	Others	Total
1977	1,115	1,125	2,241
1976	1,147	801	1,948
1975	1,363	1,079	2,442
1974	1,051	1,024	2,075
1973	932	873	1,805

# THE LOWER G.I. TRACT: ORGANICALLY SOUND

---



**Celiac angiography** is one of a number of highly specialized diagnostic techniques sometimes necessary to rule out organic causes of abdominal pain.

---

..BUT OVERSENSITIVE  
TO EMOTIONAL STRESS

---

IN IRRITABLE BOWEL  
SYNDROME\* LIBRAX  
PROVIDES DISTINCTIVE  
ADVANTAGES

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- the specific antianxiety action of Librium® (chlordiazepoxide HCl)
  - the potent antispasmodic action of Quarzan® (clidinium Br)
- 

Adjunctive/Dual-Action  
**LIBRAX**®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

A clear treatment advantage  
for patients with  
irritable bowel syndrome

---

ROCHE

\*This drug has been evaluated as possibly effective for this indication.  
Please see following page for brief summary of prescribing information.



# A CLEAR TREATMENT ADVANTAGE FOR PATIENTS WITH IRRITABLE BOWEL SYNDROME\*

Adjunctive/Dual-Action  
**LIBRAX**®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

ONLY LIBRAX PROVIDES THE SPECIFIC ANTIANXIETY ACTION OF LIBRIUM® (chlordiazepoxide HCl) PLUS THE POTENT ANTISPASMODIC ACTION OF QUARZAN® (clidinium Br)

Please consult complete prescribing information, a summary of which follows:

\* **Indications:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:  
"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.  
Final classification of the less-than-effective indications requires further investigation.

**Contraindications:** Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide hydrochloride and/or clidinium bromide.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium® (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

**Usage in Pregnancy:** Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

**Precautions:** In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacologic effects of agents, particularly potentiating drugs such as MAO inhibitors and

phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

**Adverse Reactions:** No side effects or manifestations not seen with either compound alone have been reported with Librax. When chlordiazepoxide hydrochloride is used alone, drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are avoidable in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, i.e., dryness of the mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

**Dosage:** Individualize for maximum beneficial effects. Usual maintenance dose is 1 or 2 capsules, 3 or 4 times a day, before meals and at bedtime. Geriatric patients—see Precautions.

**How Supplied:** Librax is available in green capsules, each containing 5 mg chlordiazepoxide hydrochloride (Librium®) and 2.5 mg clidinium bromide (Quarzan®)—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 50, available singly and in trays of 10.

ROCHE

Roche Laboratories  
Division of Hoffmann-La Roche Inc.  
Nutley, New Jersey 07110



## Golden Merit Awards

### President's Remarks at 1977 Ceremony\*

Last year I had the honor of bestowing this award on fifty-nine members of our Society at Cherry Hill. It was a happy occasion for them, but a sad one for me, since our President, John McGuire, had died one month previously. I am happy to be able to give this Award now to members who have lived long enough to deserve it. Longevity itself is no longer a great accomplishment, but to have practiced medicine for half a century is worthy of high praise. It represents 3200 years of compassion to the sick and injured, rendered by 64 doctors from 16 counties. For this you deserve, not just an award, but the heartfelt thanks of the many patients you have tried to help over half a hundred years.

I was a little surprised to realize that this group of recipients of the Golden Merit Award graduated just 100 years after the birth of Lord Lister—the same year that Lindbergh flew his “Spirit of St. Louis” across the Atlantic Ocean. It was also the same year that serum was introduced against measles, and that legislators in Germany abolished prostitution and passed laws on abortion. You’ve lived to see measles almost wiped out, prostitution flourish, and abortion sanctioned by the Supreme Court of our land. You’ve witnessed more medical advances in 50 years than any other generation, and you’ve contributed to these advances by your quality of practice.

During this time you’ve accumulated a knowledge that only experience can teach. Walt Whitman put it well:

Wisdom is not finally tested in schools,  
Wisdom cannot be pass’d from one having it to another  
not having it,  
Wisdom is of the soul.

To me, to be a physician is to be a member of the greatest profession known to mankind. Other professions may be more lucrative and some more divine, but none provides the satisfaction of doing good for others. As Robert Louis Stevenson said: “There are men and classes of men that stand above the common herd: the soldier, the sailor, and the shepherd not infrequently; the artist rarely; rarer still the clergyman; the physician almost as a rule. He is the flower (such as it is) of our civilisation . . . Generosity he has, such as is possible to those who practice an art, never to those who drive a trade; discretion, tested by a hundred secrets; tact, tried in a thousand embarrassments; and what are more important, Herculean cheerfulness and courage.”

Some of the younger members of our profession have yet to realize the potential a physician has in his grasp. As Rudyard Kipling said in *A Doctor's Work*—“You belong to the privileged classes.” With a stroke of your pen or a nod of your head, you can close a school, bar entrance to a restaurant, stop a ship at sea, force an airplane to land, commit a person to an institution, release a prisoner from jail, exhume a buried body, certify a birth, pronounce a death, give a narcotic, prevent a wedding, cancel a sports event, or even give orders to a president or a king. Who else wields such power, and at the same time earns such respect? Be proud that you’ve been physicians, because we’re proud of you. We thank you for sharing your talents and abilities with those who are glad to call themselves your patients.

And may you be blessed with happy days full of cheerful reflections, well-deserved nights of rest, love and respect from your families, and the appreciation of your peers for a job well-done!

---

\*John S. Madara, M.D., May 14, 1977, Atlantic City



TREAT THE SYMPTOMS IN THE GERIATRIC PATIENT

**APATHY • IRRITABILITY  
FORGETFULNESS • CONFUSION**



## **Cerebro- Nicin<sup>®</sup>** CAPSULES

**A GENTLE CEREBRAL  
STIMULANT & VASODILATOR  
FOR GERIATRIC PATIENTS**

Each CEREbro-NICIN<sup>®</sup> capsule contains:  
Pentylentetrazole 100 mg.  
Nicotinic Acid 100 mg.  
Ascorbic Acid 100 mg.  
Thiamine HCl 25 mg.  
L-Glutamic Acid 50 mg.  
Niacinamide 5 mg.  
Riboflavin 2 mg.  
Pyridoxine HCl 3 mg.

AVAILABLE: Bottles 100, 500, 1000

**SIDE EFFECTS:** Most persons experience a flushing and tingling sensation after taking a higher potency nicotinic acid. As a secondary reaction some will complain of nausea, sweating and abdominal cramps. The reaction is usually transient.

**INDICATIONS:** As a cerebral stimulant and vasodilator.  
**RECOMMENDED GERIATRIC DOSAGE:** One capsule three times daily adjusted to the individual patient.

**WARNING:** Overdosage may cause muscle tremor and convulsions.

**CONTRAINDICATIONS:** Epilepsy or low convulsive threshold.

**CAUTION:** Federal law prohibits dispensing without prescription. Keep out of reach of children.

Write for literature and samples . . .

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# Medrol<sup>®</sup> 4 mg Dosepak<sup>\*</sup>

## methyprednisolone, Upjohn

The explicit printed dosage instructions that accompany each Dosepak make it easy for the patient to understand and follow the dosage regimen.



## Trustees' Minutes

Two regular meetings of the Board of Trustees were held during the 1977 Annual Meeting in Atlantic City. Detailed minutes are on file with the secretary of your county medical society. A summary of significant actions follows:

**May 13, 1977**

*Conference of Presidents and Presidents-Elect* . . . Received information that the format for the Conference of Presidents and Presidents-Elect of Component Societies will be changed and that such conferences no longer will be held in conjunction with meetings of the Board of Trustees.

. . . Directed that a letter be written to H. Oliver Brown, M.D., President of the Union County Medical Society indicating that the Society plans to establish a new format for the Conference of Presidents and Presidents-Elect.

*Temporary Licensure* . . . Noted that Dr. Frank Begen will represent MSNJ at the State Board of Medical Examiners' meeting on temporary licensure to be held in Newark on May 18.

*Physician Consultants to the State Board of Medical Examiners* . . . Approved a request from the State Board of Medical Examiners to develop a list of practicing physicians who would be willing to act as consultants to the Board (of Medical Examiners) in selected cases.

*Hypertension Screening Program* . . . Agreed to support and endorse the hypertension program of the New Jersey State Department of Health and the efforts to secure NHLBI 77-20 "Demonstration Programs on the Impact of State-wide Coordination of High Blood Pressure Control on Control Success and Reduction of Mortality from High Blood Pressure Related Diseases."

*Laetrile* . . . Voted to take a position of **Active Opposition** on Assembly Bill 3295 which concerns the use of Laetrile in the treatment of cancer.

## *Position Statement on Medical Research . . .*

Approved the following position statement on medical research prepared by the Committee on Medical Education:

"In view of the understandable public concern about DNA recombinant (genetic) research, the Medical Society of New Jersey carefully has reviewed the scientific evidence. DNA recombinant research represents a major scientific development which has vastly expanded our ability to study the nature of genetics—in man, animals, plants, and microorganisms—and to experiment with the formation of some new forms of life. Nature has, in effect, performed DNA recombinant experiments for millions of years. This has been one way in which higher forms of life have developed. For thousands of years animal and plant breeders have tried to produce new strains with desirable characteristics through control of genetics using cross breeding but with limited success.

"Gene-splitting research has vastly enhanced the ability of scientists to investigate heredity and to explain the existence of new forms of life. This type of research appears to be the inevitable path of the future.

"The potential benefits of this research for all mankind are substantial. The greater understanding of the genetic aspects of cancer, diabetes, various anemias, and many other diseases will lead to their control. Furthermore, continued research may well produce important advances beneficial to mankind in the areas of food producing plants, sources of medication, and improvement in the breed of animals.

"Advanced DNA recombinant research also involves some risks which cannot be underestimated. Federal guidelines as outlined in the Federal Register of Thursday, September 9, 1976 assign different levels of containment for experiments with DNA from different sources. Experiments with DNA from organisms not closely related to man (plants, insects, yeast, amphibians, and so on) are considered to have little or no risk potential and require low levels of containment which are met by standard laboratory microbiological procedures. Recombinant experiments with DNA from humans or closely related species (other mammals) require more stringent levels of containment.

"Many research projects in biology and medicine, such as in polio, tuberculosis, vaccination, and many other diseases were not without risk, but the valuable advances were worthwhile. Research must continue with the same special vigilance and careful regulation observed by all true, conscientious scientists.

"The Medical Society of New Jersey, having carefully examined all the alternatives, is convinced that Federal legislation is mandatory, and must define the containments in both physical and biological terms. It is our belief that this field cannot be left to local regulation for not only will research be handicapped by the lack of uniform guidelines, but there would be serious risk of inadequate enforcement.

"The Medical Society of New Jersey therefore strongly endorses Federal legislation which will limit DNA recombinant research to specially licensed laboratories,

staffed by responsible scientists with adequate qualifications. All these laboratories—no matter whether they are in universities, private industries, or any other location—should be subject to unannounced inspection by representatives of the Federal government.

"Scientists conducting such research should be required by law to provide the government with regular reports which will enable government experts to monitor such research and to make certain that it is conducted in accordance with appropriate safeguards. Developments in this field occur rapidly and at times spontaneously; thus legislation should provide for regular review. There should be a "sunset" provision in the law which requires reevaluation of the entire field at least every five years. In this way, new developments or risks which may evolve can be incorporated into the law.

"The Medical Society of New Jersey believes that such research should be encouraged but that it must be conducted under the outlined safeguards so that the American public as well as all mankind may benefit without being exposed to hazards.

"There have been well-intentioned proposals to limit or prohibit all DNA recombinant research. The Medical Society of New Jersey opposes these proposals because they would not be in the public interest, for the public would be deprived of potential benefits. If the United States should stop all research, it would continue to be performed abroad, leaving the United States without adequate knowledge to maintain a position of scientific leadership. It is the opinion of the Medical Society of New Jersey that the United States government should do all within its power to develop, through negotiations and agreements with all nations in the world, a pact to safeguard mankind's best interests.

"Therefore, be it resolved: that the Medical Society of New Jersey believes that recombinant DNA research should be continued under the regulations outlined in the Federal register of Thursday, September 9, 1976."

*Accreditation for CME Category I Processed by AMNJ . . .* Referred to Reference Committee "D" comments of the Committee on Medical Education concerning Resolution #19 (to be introduced in the 1977 House of Delegates by the Burlington County Medical Society) dealing with scientific programs accredited for CME Category I through applications processed by the Academy of Medicine of New Jersey, which revealed that:

(1) the AMA has not authorized blanket approval for CME programs of county medical societies; (2) only 30 days advance notice should be required for accreditation; (3) the Academy should approve programs as expeditiously as possible; and (4) if MSNJ were to attempt to perform the function of the Academy in carrying out CME, the cost would be at least quadrupled.

#### *Members Delinquent in CME Credits . . .*

Directed that before a recommendation to drop members who have not complied with the mandatory CME requirement be implemented, a registered letter be sent to each of the delinquent physicians.

*Note:* At the present time there are 2,147 members delinquent in CME credits.

*Urban Health Strategy . . .* Received an informative copy of a communication from the President of the Essex County Medical Society to the Director of the Department of Health and Welfare of the City of Newark which indicated endorsement of the Director's request for assignment of National Health Service Corps physicians (1) if such physicians are limited to work only in four existing Newark owned and operated clinics (Dickinson, Dayton Street, North Newark, and Central Newark Community Health Centers; (2) if the National Health Service Corps physicians have no private office; and (3) if the National Health Service Corps physicians handle only indigent patients and serve no Medicaid or Medicare patients.

#### *Professional Liability Advertisements . . .*

Directed that a communication be sent to the Union County Medical Society explaining the error in professional liability advertisements which appeared recently in national magazines.

*Surgical Assistants . . .* Voted to reexamine the Society's current position concerning surgical assistants which stated that "the assisting physician is a physician who, under the rules and regulations of the medical staff of the given hospital, has been granted privileges to assist in the procedure being undertaken. That physician must be a licensed physician, unless he or she is serving in an approved training program as a surgical resident. The physician may or may not hold the same type of privileges as the primary surgeon. The issue is that he or she has been recognized by the medical staff and the board of trustees as being qualified to assist a primary surgeon in the operation being attempted."



*Commercial Credit Service Corporation* . . . Approved a loan proposal (at no cost to MSNJ) and vehicle-leasing program submitted by the Commercial Credit Service Corporation which would provide MSNJ members with a financial service program including unsecured loans from \$2600 to \$25,000 with preferred interest rates and maturities to 84 months, and life insurance up to \$10,000.

*AMA Section on Medical Schools* . . . Referred to the New Jersey Delegation to the AMA the investigation of the method of selecting individuals from the College of Medicine and Dentistry of New Jersey for membership in the recently organized AMA Section on Medical Schools. The following have been designated: *Chief Executive Officer*—Dr. Richard Cross, Chairman and Professor, Department of Community Medicine; *Representative 1*—Dr. Hadley Conn, Chairman and Professor, Department of Medicine; *Representative 2*—Dr. Irwin Pollack, Professor and Chairman, Department of Psychiatry; *Representative 3*—Dr. Stanley S. Bergen, Jr., President, CMDNJ.

*Gubernatorial Candidates* . . . Referred to Jempac a communication from Dr. A. Ralph Kristeller which stated that physicians have the right to ask gubernatorial candidates "who are the people you are seriously considering for the positions of Commissioner of Health and Commissioner of Insurance in your administration?"

*Resolution from the Board* . . . Approved a resolution entitled "Endorsement of AMA National Health Insurance Proposal" for presentation to the 1977 House of Delegates.

*Note:* The resolution subsequently was adopted by the House (see page Tr 125).

## May 17, 1977

*Introduction of New Members* . . . Welcomed Dr. Frank Y. Watson, 1st District, newly elected member of the Board and noted that Drs. Carter, Garrison, and Todd were re-elected.

. . . Presented Dr. George L. Benz, formerly a member of the Board of Trustees, as newly-elected Second Vice-President.

. . . Noted that Dr. Arthur Bernstein was re-elected to the office of Secretary and that Dr. Rudolph C. Gering was reelected to the office of Treasurer.

*Reorganization of the Board* . . . Reelected Dr. James S. Todd as Chairman and agreed to continue meeting regularly at 10 a.m. on the third Sunday of each month in the Executive Offices (subject to cancellation if the agenda proves insufficient).

*Committee on Finance and Budget* . . . Re-elected Dr. James S. Todd to membership on the Standing Committee on Finance and Budget for a three-year term.

*Investigation of Pharmacies* . . . Agreed, upon request from the State Board of Medical Examiners, to provide the names of physicians willing to provide prescriptions for drugs (to be used as part of an investigatory procedure covering pharmacies suspected of violating statutes regarding the dispensing of drugs) by having the personnel of the Board to so serve.

*Endorsement of AMA National Health Insurance Proposal (Resolution #35):*

RESOLVED, that the Medical Society of New Jersey believes that the 17 principles as enunciated by the AMA are essential in any form of national health insurance; and be it further

RESOLVED, that the Medical Society of New Jersey endorses the AMA's participation in the national health insurance debate and its support of health insurance through the private sector, through the introduction of S. 218 and H.R. 1818.

. . . Directed that a copy of Resolution #35 be sent to the AMA, U.S. Senators from New Jersey, Congressional Representatives from New Jersey, and appropriate U.S. legislative committees.

*Blood Replacement (Resolution #25)*

RESOLVED, that the Medical Society of New Jersey declares the withdrawal of the American National Red Cross from the National Clearinghouse Program is counter-

productive and not in the public interest; and be it further

RESOLVED, that the Medical Society of New Jersey call on the American Blood Commission and its organizational members to urge the leaders of the American National Red Cross to reconsider and support the National Blood Clearinghouse Program.

... Directed that Resolution #25 be referred to the American Red Cross, American Blood Commission, and the American Association of Blood Banks.

#### *Air Pollution (Resolution #26)*

RESOLVED, that it shall henceforth be a top priority of the Medical Society of New Jersey to (1) assay the extent of the problem (air pollution); (2) take all effective measures to familiarize the public with the implications of this deplorable situation; and (3) to define and implement corrective measures.

... Directed that Resolution #26 be forwarded to the Special Committee on Environmental Health.

#### *Sludge Pollution (Resolution #27)*

RESOLVED, that the Medical Society of New Jersey initiate action against the public health problem of pollution of our New Jersey waters; and be it further

RESOLVED, that we work toward legislation or regulations which quickly would move the present twelve-mile sludge dumping sites to 106 miles offshore until the year 1981, at which time all ocean dumping will be phased out; and be it further

RESOLVED, that the Medical Society of New Jersey send copies of this resolution to designated officials of the Environmental Protection Agency, the National Oceanic Atmospheric Agency and the Department of Environmental Protection as well as other concerned government officials.

... Directed that Resolution #27 be referred to the Council on Legislation, the Special Committee on Environmental Health, and the appropriate environmental protection agencies.

#### *Restricting the Use of Saccharin (Resolution #28)*

RESOLVED, that the Medical Society of New Jersey officially deplore the contemplated ban by the Food and Drug Administration of the United States Government of the use of the artificial sweetener, saccharin, and that the Food and Drug Administration be required to present the case to an impartial panel of top medical scientists concerning this chemical and other chemicals, such as the cyclamates, which have been under scrutiny for possible adverse effects before any ban is contemplated and most certainly before it is put into effect.

... Directed that Resolution #28 be referred to the U.S. Food and Drug Administration, U.S. Senators from New Jersey, Congressional Representatives from New Jersey, and the appropriate U.S. legislative committees.

#### *Joining the Medical Inter-Insurance Exchange (Resolution #17)*

RESOLVED, that the Medical Society of New Jersey urge the Board of Directors of the MIIIE to determine that physicians joining the MIIIE prior to June 30, 1977, shall be considered charter members; and be it further

RESOLVED, that anyone joining the MIIIE after the above date shall be required to pay an additional surcharge of 10 percent above and over the required initiation fee; and be it further

RESOLVED, that any physician first establishing his practice in the State of New Jersey shall be exempt from this requirement if he joins the MIIIE within three months of opening his office; and be it further

RESOLVED, that the Medical Society of New Jersey urge the Board of Directors of the MIIIE to determine that the MIIIE will accept no physician as an insured unless he/she is, or becomes, a member of the Medical Society of New Jersey or the New Jersey Osteopathic Society.

Reference Committee "C" recommended that the first and second "resolveds" be amended to read as follows:

RESOLVED, that the Medical Society of New Jersey urge the Board of Directors of the MIIIE to determine that physicians joining the MIIIE prior to January 1, 1979, shall be considered charter members; and be it further

RESOLVED, that anyone joining the MIIIE after the above date shall be required to pay an additional surcharge.

The House of Delegates also considered the following substitute amendment submitted by a Delegate from Essex County:

RESOLVED, that the Medical Society of New Jersey and the Board of Directors of MIIIE do all in their power to obtain the acceptance of the Commissioner of Insurance of a plan whereby there would be a certain percentage reduction in the yearly premium payments for those physicians in the MIIIE plan who are members of MSNJ or the New Jersey Association of Osteopathic Physicians and Surgeons.

... Directed that Resolution #17 and the suggested amendments thereto be referred to the Insurance Underwriters of MIIIE for study and evaluation.

#### *Physicians Starting Practice in New Jersey (Resolution #18)*

RESOLVED, that the Medical Society of New Jersey

investigate ways that a fund be established by the Inter-Insurance Exchange to loan the first year's premiums and surplus capitalization monies to all physicians just completing residency training who establish a practice of medicine or surgery in New Jersey, to be paid back over a period of three years at no interest.

Reference Committee "C" recommended that the "resolved" portion of Resolution #18 be amended to read as follows:

RESOLVED, that the Medical Society of New Jersey investigate ways that a fund could be established to loan the first year's premiums and surplus capitalization monies to all needy physicians who are about to establish a practice of medicine or surgery in New Jersey to be paid back over a period of three (3) years at minimal interest.

... Referred Resolution #18 and the suggested amendment thereto to the Insurance Underwriters of MIIE and to the Business and Finance Manager of the Medical Society of New Jersey for study and evaluation.

*Tort Law (Resolution #30)* as amended by the Reference Committee.

RESOLVED, that the Medical Society of New Jersey, in conjunction with other friendly interested parties petition and work with the State Legislature to (1) eliminate the disciplinary functions from the tort system and expand and improve other methods of discipline outside the tort system, and (2) provide for binding and contractual arbitration if defendant and plaintiff agree.

... Referred Resolution #30 to the Standing Committee on Medical Defense and Insurance.

*Reporting of Medicaid/Medicare Fees (Substitute Resolution #21)*

Whereas, the reporting of physicians' Medicaid and Medicare reimbursed fees has been widely publicized in the news media; and

Whereas, this reporting has been manifestly inaccurate, frequently confusing amounts paid to groups with amounts

paid to individuals; and

Whereas, this type of disclosure is frequently inaccurate and susceptible to gross distortions and inflammatory innuendo, casting aspersions by the media and the public concerning the vast majority of honest and ethical physicians; now therefore be it

RESOLVED, that the House of Delegates of The Medical Society of New Jersey oppose the indiscriminate release of such gratuitous information unless it has relevance to a specific allegation of abuse, fraud, or unethical practice, and be it further

RESOLVED, that the Board of Trustees and our AMA Delegates take steps to express our concern about this action.

... Referred Resolution #21 to the New Jersey Delegation to the AMA.

*Establishment of a Committee on Blood Procurement* ... Agreed with the suggestion of Reference Committee "G" that an ongoing Committee on Blood Procurement would be beneficial in lending advice and support to the complex problem of blood procurement.

*Fiscal Note* ... Referred the following resolution, approved by the House, to the Standing Committee on Finance and Budget:

RESOLVED, that where possible, the staff of the Medical Society of New Jersey provide a fiscal note on resolutions and/or reports that may commit the Society to any expenditures. (This conforms with AMA protocol.)

*Search Committee for Key State Cabinet Positions* ... Empowered President Begen to appoint a search committee to select suitable candidates from among New Jersey physicians for key positions in the State Cabinet—Commissioner of Health, Commissioner of Environmental Protection, and Commissioner of Human Services.

Support the Society for  
Relief of Widows and Orphans

(P.O. Box 102, Hopewell, N.J.)



AMA

Where do you stand on these issues?

Pro Con

- ☐ ☐ Maternal and child care programs
- ☐ ☐ Federal aid to medical students
- ☐ ☐ Extending private health insurance to everyone
- ☐ ☐ Nationwide program of community emergency medical services
- ☐ ☐ Reform of the tort system of malpractice adjudication
- ☐ ☐ Maximum Allowable Cost (Drug) Regulations
- ☐ ☐ Health Planning Act of 1974
- ☐ ☐ Federal control of the number and location of residences
- ☐ ☐ Federal standards for licensure and relicensure
- ☐ ☐ Federal national health service

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- The patient with hyperthyroidism
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(Vitamin B<sub>6</sub>) . . . . . 5 mg  
Niacinamide . . . . . 100 mg  
Calcium pantothenate . . . . . 20 mg  
Cyanocobalamin  
(Vitamin B<sub>12</sub>) . . . . . 5 mcg  
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**Indications:** Nutritional supplementation in conditions in which water-

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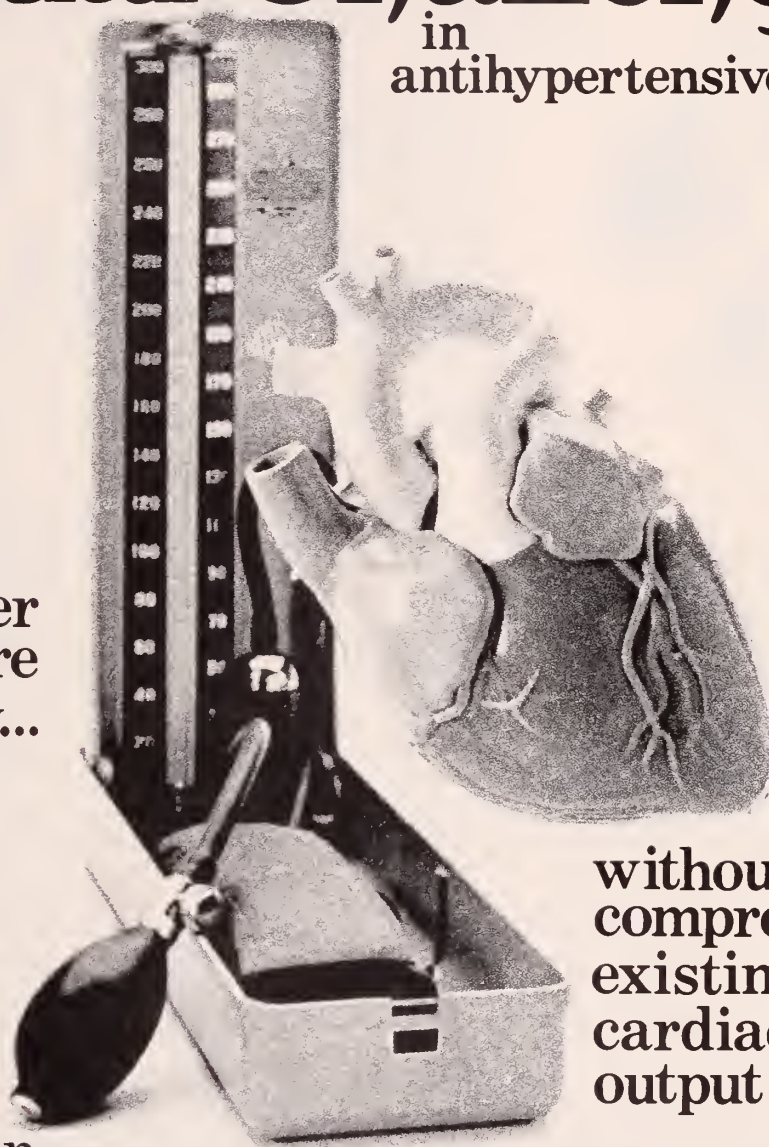


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Nutley, New Jersey 07110

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in  
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to lower  
blood pressure  
effectively...



without  
compromising  
existing  
cardiac  
output

in hypertension

TABLETS: 250 mg, 500 mg, and 125 mg

# ALDOMET<sup>®</sup> (METHYLDOPA | MSD)

helps lower blood pressure effectively...  
usually with no direct effect on  
cardiac function—cardiac output  
is usually maintained

ALDOMET is contraindicated in active hepatic disease, hypersensitivity to the drug, and if previous methyldopa therapy has been associated with liver disorders.

It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. For more details see the brief summary of prescribing information.

For a brief summary of prescribing information, please see following page.

**MSD**  
MERCK  
SHARP  
DOHME





in hypertension

# ALDOMET<sup>®</sup>

(METHYLDOPA|MSD)

helps lower  
blood pressure  
effectively...  
usually with no  
direct effect on  
cardiac function—  
cardiac output is  
usually maintained

**Contraindications:** Active hepatic disease, such as acute hepatitis and active cirrhosis; if previous methyldopa therapy has been associated with liver disorders (see Warnings); hypersensitivity

**Warnings:** It is important to recognize that a positive Coombs test, hemolytic anemia, and liver disorders may occur with methyldopa therapy. The rare occurrences of hemolytic anemia or liver disorders could lead to potentially fatal complications unless properly recognized and managed. Read this section carefully to understand these reactions.

With prolonged methyldopa therapy, 10% to 20% of patients develop a positive direct Coombs test, usually between 6 and 12 months of therapy. Lowest incidence is at daily dosage of 1 g or less. This on rare occasions may be associated with hemolytic anemia, which could lead to potentially fatal complications. One cannot predict which patients with a positive direct Coombs test may develop hemolytic anemia. Prior existence or development of a positive direct Coombs test is not in itself a contraindication to use of methyldopa. If a positive Coombs test develops during methyldopa therapy, determine whether hemolytic anemia exists and whether the positive Coombs test may be a problem. For example, in addition to a positive direct Coombs test there is less often a positive indirect Coombs test which may interfere with cross matching of blood.

At the start of methyldopa therapy, it is desirable to do a blood count (hematocrit, hemoglobin, or red cell count) for a baseline or to establish whether there is anemia. Periodic blood counts should be done during therapy to detect hemolytic anemia. It may be useful to do a direct Coombs test before therapy and at 6 and 12 months after the start of therapy. If Coombs-positive hemolytic anemia occurs, the cause may be methyldopa and the drug should be discontinued. Usually the anemia remits promptly. If not, corticosteroids may be given and other causes of anemia should be considered. If the hemolytic anemia is related to methyldopa, the drug should not be reinstituted. When methyldopa causes Coombs positivity alone or with hemolytic anemia, the red cell is usually coated with gamma globulin of the IgG (gamma G) class only. The positive Coombs test may not revert to normal until weeks to months after methyldopa is stopped.

Should the need for transfusion arise in a patient receiving methyldopa, both a direct and an indirect Coombs test should be performed on his blood. In the absence of hemolytic anemia, usually only the direct Coombs test will be positive. A positive direct Coombs test alone will not interfere with typing or

cross matching. If the indirect Coombs test is also positive, problems may arise in the major cross match and the assistance of a hematologist or transfusion expert will be needed.

Fever has occurred within first 3 weeks of therapy, sometimes with eosinophilia or abnormalities in liver function tests, such as serum alkaline phosphatase, serum transaminases (SGOT, SGPT), bilirubin, cephalin cholesterol flocculation, prothrombin time, and bromsulphalein retention. Jaundice, with or without fever, may occur, with onset usually in the first 2 to 3 months of therapy. In some patients the findings are consistent with those of cholestasis. Rarely fatal hepatic necrosis has been reported. These hepatic changes may represent hypersensitivity reactions; periodic determination of hepatic function should be done particularly during the first 6 to 12 weeks of therapy or whenever an unexplained fever occurs. If fever and abnormalities in liver function tests or jaundice appear, stop therapy with methyldopa. If caused by methyldopa, the temperature and abnormalities in liver function characteristically have reverted to normal when the drug was discontinued. Methyldopa should not be reinstituted in such patients.

Rarely, a reversible reduction of the white blood cell count with primary effect on granulocytes has been seen. Reversible thrombocytopenia has occurred rarely. When used with other antihypertensive drugs, potentiation of antihypertensive effect may occur. Patients should be followed carefully to detect side reactions or unusual manifestations of drug idiosyncrasy.

**Use in Pregnancy:** Use of any drug in women who are or may become pregnant requires that anticipated benefits be weighed against possible risks; possibility of fetal injury can not be excluded.

**Precautions:** Should be used with caution in patients with history of previous liver disease or dysfunction (see Warnings). May interfere with measurement of uric acid by the phosphotungstate method, creatinine by the alkaline picrate method, and SGOT by colorimetric methods. Since methyldopa causes fluorescence in urine samples at the same wavelengths as catecholamines, falsely high levels of urinary catecholamines may be reported. This will interfere with the diagnosis of pheochromocytoma. It is important to recognize this phenomenon before a patient with a possible pheochromocytoma is subjected to surgery. Methyldopa is not recommended for patients with pheochromocytoma. Urine exposed to air after voiding may darken because of breakdown of methyldopa or its metabolites.

Stop drug if involuntary choreoathetotic movements occur in patients with severe bilateral cerebrovascular disease. Patients may require reduced doses of anesthetics; hypotension occurring during anesthesia usually can be controlled with vasopressor. Hypertension has recurred after dialysis in patients on methyldopa because the drug is removed by the procedure.

**Adverse Reactions:** *Central nervous system:* Sedation, headache, asthenia or weakness, usually early and transient; dizziness, lightheadedness, symptoms of cerebrovascular insufficiency, paresthesias, parkinsonism, Bell's palsy, decrease mental acuity, involuntary choreoathetotic movements; psychic disturbances, including nightmares and reversible mild psychoses or depression.

**Cardiovascular:** Bradycardia, aggravation of angina pectoris. Orthostatic hypotension (decrease in dosage). Edema (and weight gain) usually relieved by use of a diuretic. (Discontinue methyldopa if edema progresses or signs of heart failure appear.)

**Gastrointestinal:** Nausea, vomiting, distention, constipation, flatulence, diarrhea, mild dryness of mouth, sore or "black" tongue, pancreatitis, sialadenitis.

**Hepatic:** Abnormal liver function tests, jaundice, liver disorders.

**Hematologic:** Positive Coombs test, hemolytic anemia, leukopenia, granulocytopenia, thrombocytopenia.

**Allergic:** Drug-related fever, myocarditis.

**Other:** Nasal stuffiness, rise in BUN, breast enlargement, gynecomastia, lactation, impotence, decreased libido, dermatologic reactions including eczema and lichenoid eruptions, mild arthralgia, myalgia.

**Note:** Initial adult dosage should be limited to 500 mg daily when given with antihypertensive other than thiazides. Tolerance may occur, usually between second and third month of therapy; increased dosage or adding a thiazide frequently restores effective control. Patients with impaired renal function may respond to smaller doses. Syncope in older patients may be related to increased sensitivity and advanced arteriosclerotic vascular disease; this may be avoided by lower doses.

**How Supplied:** Tablets, containing 125 mg methyldopa each, in bottles of 100; Tablets, containing 250 mg methyldopa each, in single-unit packages of 100 and bottles of 100 and 1000; Tablets, containing 500 mg methyldopa each, in single-unit packages of 100 and bottles of 100.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486 J6AM07 (70)

**MSD** MERCK SHARP & DOHME

# THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

Publisher: The Medical Society of New Jersey  
P.O. Box 904  
Trenton, N.J. 08605

Advertising Representative: United Media Associates  
16 Bruce Park Avenue  
Greenwich, Conn. 06830  
(203) 661-9702

## General Information

### 1. Issuance:

- a. Frequency: Monthly
- b. Issue date: 10th of month.
- c. Mailing date: 10th of month

### 2. Established: 1904

### 3. Organization Affiliation:

Official publication of  
The Medical Society of New Jersey.

### 4. Circulation Data:

a. Controlled circulation to all members of The Medical Society of New Jersey. Members' subscription (\$5) is included in Society dues. Rates for non-members \$10, outside USA add \$2.50 for postage. Single copies \$1.

b. Annual percentage of subscription renewals: 100% of members.

c. Number of issues sent after subscription expiration: None.

### 5. Special Issues: Convention (April); Annual Transactions (July or August); Index (December)

6. **Editorial Content:** Original scientific articles, special articles, case reports, editorials, medical news and meeting notices, trustees' minutes, communicable disease reports, state legislation, convention, medical insurance, PSRO, education, etc.

### 7. Requirements for Acceptance of New Professional Products for Advertising.

All advertising subject to Publication Committee approval.

### 8. Requirement for Advertising Clearance:

All advertising subject to Publication Committee approval.

### 9. Advertising Acceptance of Nonprofessional Products or Services:

All advertising subject to Publication Committee approval.

### 10. Policy on Placement of Advertising:

Advertising is interspersed throughout the publication. All R.O.B. ads are rotated each month. Advertising and editorial material is not placed on the same page.

### 11. Advertisers' Index: No.

### 12. Services to Advertisers:

- a. Availability of mailing list: Availability subject to approval by Board of Trustees.
- b. Availability of editorial reprints: Please direct such requests to the Editor.

### 13. Staff:

Editor: Arthur Krosnick, M.D. Associate Editors: William A. Dwyer, Jr., M.D.; Bernard D. Pinck, M.D.; Richard H. Rapkin, M.D. Assistant Editor: Marjorie D. Treptow; Executive Director: Vincent A. Maressa.

### 14. Circulation:

All members of the Medical Society of New Jersey.

### 15. Guaranteed Circulation:

All members of the Medical Society of New Jersey.

### 16. Circulation Verification:

Publisher's statement, postal receipt verification.

### 17. Rates Per Thousand:

Based on the 12-times rate of \$220 and circulation of 10,000: \$22.00

# THE JOURNAL of The Medical Society of NEW JERSEY

Rate Card effective January 1977

**18. Coverage and Market**

a. Coverage: All members of The Medical Society of New Jersey, plus trade circulation of approximately 650 medical libraries, drug manufacturers, medical book publishers, medical abstract services, advertisers, advertising agencies, subscriptions. Circulation figures as of 6-1-77.

b. GP .....	3,130
IM .....	1,789
GS .....	1,374
OBG .....	775
PED .....	647
DERM .....	186
ALL .....	79
UROL .....	206
EMT .....	411
PSYCH .....	607
OPH .....	363
RETIRED .....	245
TOTAL .....	9,812
c. Trade Circulation:	
Non-member physicians	
Medical libraries	
Medical schools	
Drug manufacturers	
Medical book publishers	
Medical abstract services	
Advertisers	
Advertising agencies	
Subscriptions	
Total approximately .....	650

**19. MEMBERSHIP CIRCULATION BY  
COUNTIES OF STATE OF NEW JERSEY**

Atlantic .....	23
Bergen .....	1,20
Burlington .....	28
Camden .....	59
Cape May .....	5
Cumberland .....	14
Essex .....	1,88
Gloucester .....	11
Hudson .....	60
Hunterdon .....	7
Mercer .....	63
Middlesex .....	63
Monmouth .....	60
Morris .....	52
Ocean .....	23
Passaic .....	79
Salem .....	5
Somerset .....	18
Sussex .....	7
Union .....	83
Warren .....	8
Total .....	9,81

Guaranteed Circulation: 10,000



# THE JOURNAL of The Medical Society of NEW JERSEY

Rate Card effective January 1977

## Rates

### 20. Issuance:

- a. Frequency: Monthly
- b. Issue Date: 10th of month
- c. Mailing date: 10th of month.

### 21. Closing Dates for Space:

- a. Reservations: 1st of month preceding month of issue
- b. Cancellations: 6th of month preceding month of issue

### 22. Agency Commission: 15%

### 23. Cash Discount: 2%, 10 days.

### 24. Rates:

	1 time	3 times	6 times	12 times	
1 page	260	250	240	220	Classified: Available to member physicians only.
1/2 page	150	140	130	120	
1/4 page	70	65	60	55	
1/8 page	50	45	40	35	

### 25. Earned Rates:

Rates based on number of insertions used within one year, regardless of size. Space purchased by a parent company and subsidiaries is combined for accounting of earned rates.

### 26. Color Rates:

- a. Standard color \$120 plus earned black and white rate.
- b. List of standard colors: AAAA standard red, green, blue, yellow, orange.
- c. Matched Colors: \$130 plus earned black and white rate.
- d. 3-color rate: \$390 plus earned black and white rate
- e. 4-color rate: \$440 plus earned black and white rate.

### 27. Bleed: 10%

### 28. Inserts:

60 pound coated only.

### 29. Preferred Position Rates:

- a. Preferred position rates quoted on request and subject to availability.
- b. Should an advertiser insist on a specific position, production requirements may dictate premium rates.

### 30. Miscellaneous:

- a. Contract requirements: All contracts subject to publisher's approval.
- b. Statement of guarantee of uniform rates and discounts to all advertisers using same amount and kind of space: No exceptions to published rates.
- c. Concessions: None
- d. Rates subject to change with 90 days notice. Contracts accepted with understanding that rates will be guaranteed for three months beyond last issue closed. In the event of rate increase, contracts may be terminated without penalty of short rate.

# THE JOURNAL of The Medical Society of NEW JERSEY

Rate Card effective January 1977

## Mechanical Requirements

THE JOURNAL is printed by offset.

Trim size: 8 x 11

### 31. Plate Sizes:

Page Unit	Dimensions
1 full page	7 x 10
½ horizontal	7 x 4⅞
½ vertical	3⅜ x 10
¼ horizontal	7 x 2⅜
¼ vertical	3⅜ x 4⅞
⅛ horizontal	7 x 1⅞
⅛ vertical	3⅜ x 2⅜

### 32. Bleed Size

Page Unit	Dimensions
1 full page	8⅞ x 11¼

### 33. Insert Requirements

Untrimmed size — 8¼ x 11¼

### 34. Paper Stock: Covers: 80-pound.

Inside pages: 60 pound.

### 35. Type of Binding: Perfect bound.

### 36. Halftone Screen: Up to 133 screen

### 37. Reproduction Requirements:

Black and white positives and 2-color advertisements: negatives, camera-ready mechanicals, and art work acceptable.

4-color: film negatives or positive separations and press proof.

Offset film negatives or positives on .002 or .004 stable base materials must have register marks, center marks, and trim marks clearly indicated. Each negative must be marked for color and be right reading emulsion side down.

### 38. Closing Dates:

a. Negatives or positives, camera ready mechanicals, and art work: 10th of the month preceding month of issue.

b. Publication set copy: 5th of month preceding month of issue.

### 39. Disposition of Reproduction Material:

Material is held for one year and then destroyed.

## EMERGENCY ROOM PHYSICIAN

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(609) 348-1161

## SEE

Hospitals ..... pages 603, 634  
Personnel ..... pages 618, 641  
Real Estate ..... pages 640, 641

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Call (201) 992-4162  
Between 4:30 & 7:00 PM

## SEE

Hospitals ..... pages 603, 634  
Personnel ..... pages 618, 639, 641  
Postgraduate Course ..... page 642  
Real Estate ..... page 641

# CLASSIFIED ADVERTISEMENTS

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


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\* **WRITE FOR REPRINT:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D. "Hormones for Improved Sexuality in the Male and Female Climacteric." *Drug Therapy*, Sept. 1976.

Is there a true aphrodisiac? How effective are androgens in the management of the male climacteric and male impotence? Article discusses the psychophysiological and hormonal changes in the elderly male and female and therapeutic considerations. The effectiveness of methyltestosterone in the management of male impotence was confirmed by a cross-over, double-blind study using a placebo and Android-25

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**DESCRIPTION:** Methyltestosterone is 17 $\beta$ -Hydroxy-17-Methylandrosta-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-pubertal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

**REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. In the male: Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpubertal cryptorchidism, 30 mg. **REFERENCE:** Robert B. Greenblatt, M.D., and D. H. Perez, M.D.: "The Menopausal Syndrome," *Problems of Libido in the Elderly*, pp. 95-101. Medcom Press, N.Y., 1974. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only

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For practitioners and nurse anesthetists to improve and update skills in clinical anesthesia. Stress is on new management and care concepts, especially in circulation, respiration, anesthetic agents, obstetrics, neuroanesthesia and pediatrics. Includes group workshops in respiratory care and a special session on government regulation and malpractice. Review will assist in preparation for the ADA oral examination. Tuition \$100 for residents and nurse anesthetists. (21 AMA Category 1 credit hours.)

### Clinical Rheumatology for Primary Physicians

**Tuition \$165\*** October 9-10  
Practical knowledge and application of the newest developments in the diagnosis and treatment of the rheumatic diseases. Special attention to the more common disorders such as rheumatoid arthritis, gout, osteoarthritis and various musculoskeletal syndromes. Problem cases are presented and discussed. Several concurrent lectures in Spanish are offered. (14 AAFP prescribed hours; 14 AMA Category 1 credit hours.)

### Introduction to Medical Genetics for Primary Physicians

**Tuition \$165\*** October 11-12  
Basic concepts and genetic terminology are defined. Differential diagnosis with emphasis on inborn errors of metabolism is reviewed with special attention to practical application in clinical situations. Office counseling and treatment including dietary and replacement therapy and the implications of genetic screening are considered (14 AAFP prescribed hours; 14 AMA Category 1 credit hours.)

### General Diagnostic Radiology

**Tuition \$275** October 10-14  
An in-depth survey of all subspecialties of diagnostic radiology including neuroradiology and bone and joint radiology. Basic concepts and practical clinical applications are reviewed with particular attention to currently accepted procedures as well as newer developments, e.g., computerized tomography and its application to the trunk and head. A refresher course for practicing radiologists and a review for candidates preparing for radiology exams. Tuition \$175 for residents, fellows and military personnel. (30 AMA Category 1 credit hours.)

### Dermatological Diagnosis & Management For The Primary Physician

**Tuition \$200\*** October 26-28  
Common dermatologic problems are considered with emphasis on unraveling diagnostic possibilities in a presenting complaint and providing relief of the patient's symptoms while the evaluation is underway. Format includes clinical presentations and a workshop on therapeutics. (21 AAFP prescribed hours; 21 AMA Category 1 credit hours.)

### Introduction to Echocardiography

**Tuition \$165\*** October 20-21  
Basic physical concepts of sound and ultrasound are reviewed, echocardiographic equipment is described and demonstrated and examination techniques are illustrated. Indications for examination in adults and children are presented and the echocardiographic patterns of patient problems commonly seen in practice are examined. Assumes no previous experience with the subject. Will assist physicians evaluate their patients' echocardiograms and intelligently interpret the literature. (14 AAFP prescribed hours; 14 AMA Category 1 credit hours.)

### Office Management of Common Orthopedic Problems for Emergency Department and for Primary Physicians

**Tuition \$165\*** October 22-23  
An intensely practical review of the diagnosis and management of common orthopedic problems as seen in the office and emergency room. Topics include neck and shoulder pain, hand trauma, low back pain and disc disease, the painful hip, the painful knee, the sprained ankle, common foot problems and frequently missed fractures. Instructors stress their personalized approach to diagnosis and management. (14 AAFP prescribed hours; 14 AMA Category 1 credit hours, Emergency Medicine credit pending.)

### Hypnosis in Clinical Practice

**Tuition \$165\*** October 29-30  
A practical demonstration on how and when to employ hypnosis in office practice. The use of the Hypnotic Induction Profile (test and measure of hypnotizability) is taught as a diagnostic tool and a therapeutic agent in the treatment of smoking, weight control, management of pain, seizure disorders, control of breathing disorders, blood pressure, functional cardiac arrhythmias and the management of phobic reactions. The relation of hypnosis to TM, yoga, biofeedback and acupuncture is examined. (14 AAFP prescribed hours; 14 AMA Category 1 credit hours.)

### Additional Courses—Fall 1977

- Management of the Alcoholic and the Alcoholic Abuser—Oct. 13-15
- Internal Medicine: An In-Depth Review—Jan.-April, 1978
- Diagnosis of Inflammatory Skin Diseases (dermatologists, pathologists)—Oct. 13-15
- Helping Children Cope—Oct. 15
- Hatchiss Symposium on Male Infertility—Nov. 5-6
- Diagnosis of Muscular Disease for Primary Physicians—Nov. 11
- Neurosurgery/New York City 1977—Nov. 28-Dec. 1
- Uradynamics—Dec. 3-6
- Clinical Diagnosis of Neuromuscular Disease—Dec. 8-9

\*Tuition includes continental breakfast, lunch and refreshments, and written materials.

For more detailed information write or phone: Registration Department, NYU Post-Graduate Medical School, 550 First Avenue, New York, NY 10016; (212) 679-3200, Ext. 4038.



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# EDITORIALS

## Medicare and Medicaid Fraud

A front-page photograph of a recent issue of *The New York Times* portrayed eleven podiatrists handcuffed and chained together—"standard procedure when moving a group in a felony arrest." This group was indicted on "charges of conspiracy and attempted bribery." The investigators attributed the bribery scheme to the group's attempt to block New York State's proposal to eliminate podiatry services from Medicaid coverage.

A Philadelphia physician pleaded guilty to fraudulent billing of Medicare and receiving payments for services allegedly performed in his office. The court sentenced him to a sizable fine, probation for five years, coupled with thrice-weekly charity work. Another physician was sentenced to a Federal prison term for similar dishonest practices—with devastating effects on his wife and children.

What can one say about Medicare or Medicaid fraud? Can one explain it, justify it, or excuse it? Can one countenance mail fraud, bank embezzlement, income tax evasion, or election frauds?

Fraud is an intentional breach of the law—a perversion of truth—which entails deception for the purpose of gain. Medicare and Medicaid fraud violate both state and federal law—a not inconsiderable endangerment.

There is no ethical, moral, social, constitutional, or other justification for a physician to break the laws relating to Medicare and Medicaid. The small proportion of physicians, podiatrists, and other health professionals who have been punished for such infractions have the rest of their lives to realize that, but how does one explain such actions to his family, to his patients, to himself?

Most physicians—like most podiatrists, dentists, and lawyers—are honest. In every group of human beings there will be those who participate in illegal, criminal, immoral, or unethical behavior patterns. Predictably, however, the image of many may be tainted by the misconduct of a few.

There is no place in medical practice or medical research or medical education for the circuitous illogical reasoning which may seem to justify falsification of clinical records, laboratory results, or research findings. When temptation appears, the final test is not difficult. Was it worth the overwhelming stress of study in high school and college, the pressures of medical school interviews and applications, the rigors of medical education, internship, and post-graduate study, the denial of personal and family pleasures to reach a professional zenith from which one may be toppled by monetarily-based misconduct? The answer, fortunately, is quite clear to the vast majority of the medical profession. Hopefully, the same conclusion should be clear to the general citizenry at large and to our governmental representatives who should recognize that most physicians do not participate in Medicare or Medicaid fraud.

These situations are indeed unfortunate. The medical profession must condemn such misconduct whenever and wherever it occurs. A.K.

## Prison Medicine in New Jersey and in the United States

In Milwaukee this month the American Medical Association is sponsoring a national conference dealing with "health care in jails." The conference is related to a pilot program "to improve medical care and health services in the jails" in six states. The project, which is sponsored and staffed by the AMA with a financial grant from the Law Enforcement Assistance Administration of the U.S. Department of Justice, involves the state medical societies in Georgia, Indiana, Maryland, Michigan, Washington, and Wisconsin.

New Jersey recently had some experience with purported "negligent medical care" of a diabetic prisoner in the State Prison at Trenton. The result of a court hearing was the cancellation of 10 years of a 10 to 12-year imprisonment by the sentencing judge, based on his decision that the prisoner could not receive adequate care for his diabetes. This case was similar to "some successful lawsuits on behalf of prisoners in which a federal court ruled that inadequate medical care constituted cruel and unusual punishment, and was a violation of inmates' constitutional rights."\*

Evaluation of the quantity and quality of medical care in New Jersey prisons is not an easy task—just as the provision of such care by physicians, nurses, technicians, and paramedical assistants is not a simple matter. By their very nature, prisoners in general tend to be manipulative, uncooperative, non-compliant, evasive, and even hostile to those health professionals who are trying to help them. Unfortunately, decisions such as those described above, which are humane, tend to encourage the manipulative prisoner to become more so in the hope of gaining early release on grounds of inadequate health care. This is especially true of those prisoners with chronic diseases such as diabetes, in which patient cooperation is so important. Diet, for example, can be altered grossly by the prisoners through the barter or sale of food items, and some prisoners have refused to permit nurses to give injections of insulin and have refused to permit performance of blood tests. Urine tests are easily distorted.

In crisis-intervention fashion, the New Jersey Department of Corrections, the Superintendent and the Medical and Clinical Directors of the Trenton State Prison, and the Medical Consultant to the Department of Human Services instituted a program of reform for diabetes care. This included intensive training of professional and staff members in diabetes management, a new method of rapid blood glucose determinations, inauguration of dietetic services with development of special diets for diabetics, an

identification system for diabetic prisoners, and so on. Although this program is commendable and a start in the right direction, there is much more to be done relative to chronic diseases and even for geriatric problems. Some prisoners remain incarcerated well into their sixties; there was one past ninety.

The national pilot program "seeks improvement in health care in jails, and a long-range objective is development of a national accreditation system for jail medical programs, similar to accreditation programs now in force for hospitals and medical schools." In the meantime one must make a plea for reason. In evaluating health care in prisons, one must not judge its quality against the standard of health care in the outside world. To be fair, one must compare one prison's medical service against another prison—not against a university hospital or out-patient department. The national accreditation system is a sensible one which obviously will adhere to this concept.

A former Georgia governor once complained that the problem in that state was not a poor prison system but a low class of prisoners. Be that as it may, New Jersey jails and prisons have human beings behind their bars and they are entitled to health care services. The Medical Society of New Jersey should be cognizant of the national program and its recommendations and assist in the development of high-level prison medicine in our state.

A.K.

## Have You No Complaints?

At the 211th Annual Meeting of MSNJ, the report of the Membership Inquiries and Complaint Committees was accepted and filed in the House of Delegates. The chairman pointed out that the services of the committees are underutilized and suggested that this be brought to the attention of the membership at large.

The original impetus for the establishment of an inquiry and complaint mechanism came in the form of a resolution from the Essex County Medical Society to a special session of the

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\*AMA, Director of Public Relations News Release, May 30, 1977



House of Delegates in December 1972. The resolution was adopted and referred by the Board of Trustees to the Executive Committee for implementation. Committees called for in the resolution were established and a third-party membership complaint form—a masterpiece of simplicity—was prepared and supplied to all county societies.

Any MSNJ member who has a specific problem with a carrier or intermediary, whether it be Medicare, Medicaid, Blue Shield, or other, should avail himself of the Society's service. If you have a complaint, let it be known. If you are uncertain, write or call Mr. Joseph C. Lucci, Executive Assistant at MSNJ's offices in Trenton. A.K.

## Audit the Audits

The hospital-medical audit is a fact of life. Be that as it may, one still may be inquisitive.

Do audits do any good? Do they teach physicians, nurses, and other health personnel anything? Do the hospital administrators or the Boards of Trustees benefit from medical audits? Do audits provide a prospective advantage to patients yet untreated? Do they control costs or curtail over-utilization?

The answers to these questions are not readily available. Nor is the ultimate question—Is medical audit, as presently conducted, worthwhile?—answerable.

A brief look at the medical and nursing audits in one urban hospital in 1976 revealed the following:

Medical and nursing audits in 1976—20.

Weeks required for audits—47.

Staff time in 1976 spent on audits—418 hours.

Approximate time spent per audit—18 hours.

Meeting time—49½ hours.

Duties of audit staff:

- pulling and filing records
- data retrieval (abstracting each chart for criterial compliance) display and analysis, preparation of reports (20 photocopies per meeting)
- attending criteria and data review meetings, nursing audit meetings, and medical audit meetings (at least four to five hours per month).
- special reports and retrieval of information for administration and utilization departments, director of Medical Affairs, and physicians.

The time spent easily can be converted to dollar equivalents, but this represents only staff activity. How about physician time—at the committee meetings and department reviews? Once more we see that government regulations cost time and money, but who pays the bill?

If we are going to be required to do audits, it makes sense to dissect the audits. If they are non-productive as presently performed, we should consider changing them. We should do them less frequently but more intensively. Or, select problem areas and focus on the lessons to be learned. In no case should the audit be done as a routine chore to satisfy the inquisitors. At year's end, let's audit the audits. A.K.

### Cover

The photograph from which this month's cover was prepared was taken by M. Jay Goodkind, M.D., Trenton cardiologist, who also provided the original material for the February and May covers.

# **COLBY PROCLAIMS WOMAN SUFFRAGE**

**Signs Certificate of Ratification  
at His Home Without  
Women Witnesses.**

**MILITANTS VEXED AT PRIVACY.**

**Wanted Movies of Ceremony,  
But Both Factions Are**

**WASHINGTON, Aug. 26, 1920—**  
The struggle for woman



# **TRUMAN CLOSES UNITED NATIONS CONFERENCE WITH PLEA TO TRANSLATE CHARTER INTO DEEDS**

## **NEW WORLD HOPE**

**President Hails 'Great  
Instrument of Peace,'  
Insists It Be Used**

## **HISTORIC LANDMARK**

**Meeting Gives Standing  
Ovation as Executive  
Pictures Peace Gain**

# **Social Security Bill Is Signed Gives Pensions to Aged, Jobless**

**Roosevelt Approves Message Intended to Benefit 30,  
Million Persons When States Adopt Cooperating Laws—He  
Calls the Measure 'Cornerstone' of His Economic Program**

## **SENATE APPROVES 18-YEAR OLD VOTE IN ALL ELECTIONS**

**Amendment to Constitution  
is Sent to House, Where  
Passage is Expected**

**WASHINGTON, March 10,  
1971—The Senate approved  
today, 94 to 0, and sent to**

**WASHINGTON, Aug.**  
The Social Security Bill,  
a broad program of unemploy-  
ment insurance and old age  
pensions and counted upon to ben-  
efit 20,000,000 persons, became  
law today when it was signed by  
President Roosevelt in the presence  
of those chiefly responsible for  
drafting it through Congress.

Mr. Roosevelt called the bill  
"the cornerstone in a new  
program which is being built to  
meet the needs of the people  
in the new world."

# **the Draft Ends No**

**WASHINGTON, Jan. 27,  
1973—"With the signing of  
the peace agreement in  
Paris today, and after re-  
ceiving a report from the  
Secretary of the Army that**

"If we fail to use it," he declared  
to the solemn final meeting of the  
delegates, "we shall betray all of  
those who have died in order that  
we might meet here in freedom and  
safety to create it."

"If we seek to use it selfishly—for  
the advantage of any one nation or  
any small group of nations—we  
shall be equally guilty of that be-  
trayal."

### **Fervent Interpolation**

The President, speaking in the  
auditorium of the War Memorial  
Opera House, built in memory of  
sons of the Golden Gate city who  
gave their lives in the first World  
War, in which he himself served,  
seemed to give unconscious expres-  
sion to the solemn feeling of the  
occasion when, at the outset of his  
speech, he interpolated the words,  
half a hope, half a prayer:

"Oh, what a great day this can  
be in history!"

Just before the plenary session  
the President, after a brief



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# PATIENT PACKAGE INSERTS: A CONCEPT WHOSE TIME HAS COME?

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*The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely-prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.*

*The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.*

## **The Advantages**

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

Every doctor has had patients who fail to finish antibiotic regimens because they feel better. Some patients assume that if one tranquilizer or analgesic is good, two may be twice as good. Still others fail to report dizziness while on antihypertensive therapy—and so on.

Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

## **The Disadvantages**

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information

is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

## **The Solution**

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.

**PMA**

THE PHARMACEUTICAL MANUFACTURERS ASSOCIATION  
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# ORIGINAL ARTICLES

*Hyperalimentation is a reliable and practical technique to convert depleted patients with enterocutaneous fistulas to positive nitrogen balance. Complete healing of fistulas may occur with TPN but for many of these patients hyperalimentation prepares the patient for surgery. Notable complications of hyperalimentation include hyperosmolar dehydration and sepsis. The operative procedure of choice on the fistulous tract is complete excision and end-to-end anastomosis, utilizing a lateral approach whenever possible.*

## Enterocutaneous Fistulas

### Management with Hyperalimentation and Surgery\*

**I. Dardik, M.D., H. Dardik, M.D.,  
M. Levy, M.D., and I. M. Ibrahim, M.D.,  
Fort Lee; I. Peyser, M.D., Boonton; and  
A. Koslow, B.S.**

The surgical literature is replete with articles dealing with enterocutaneous fistulas, all attesting to the formidable problems besetting the physician who must care for the patient with this complication. Prior to total parenteral nutrition (TPN), the mortality for high output fistulas was about 60 percent and for low output fistulas, 15 to 20 percent. With the advent of TPN, the overall mortality ranges from 5 to 20 percent. The majority of these patients were never able to tolerate corrective operation, and died from acute intra-abdominal sepsis or slow deterioration from electrolyte imbalance, protein depletion, and malnutrition. The principles governing the successful management of enterocutaneous fistulas have now been defined as follows: (1) reversing the catabolic state, (2) replacing electrolyte and fluid losses, (3) controlling associated infections and (4) local care of the surrounding skin.

Until recently nutritive and electrolyte support was supplied by intravenous solutions of five or ten percent dextrose with the addition of albumin and blood as needed. If the fistulous tract was located high in the alimentary tract a long tube was passed distal to the fistula and blenderized feedings were delivered by Barron pump. Alternatively, the fistulous output as well as blenderized feedings were fed through a distal feeding jejunostomy. Unfortunately, this approach was applicable in only a small percentage of patients, since it frequently was

hampered by intractable diarrhea and the dumping syndrome.

The major cause of enterocutaneous fistulas is intraoperative injury of the intestine or anastomotic leakage. Other common causes of fistulization are Crohn's disease, ulcerative colitis, perforated diverticulitis, malignant disease with perforation, and radiation enteritis.

We have found it imperative that all patients with an enterocutaneous fistula undergo a complete evaluation with prior resuscitation of fluids and electrolytes. All patients undergo a fistulogram, upper gastrointestinal series, small bowel study and barium enema. After these tests are performed one then can decide on the course of management, i.e., TPN, surgical intervention, drainage of an intra-abdominal abscess or any combination of the above.

The introduction of intravenous hyperalimentation by Dudrick and Rhoads<sup>7</sup> was a major innovation in the management of enterocutaneous fistulas. They conclusively demonstrated that this was a practical method to place the alimentary tract at rest and to regain positive nitrogen balance. Patients with enterocutaneous fistulas were able to gain weight and, in a certain percentage, spontaneously close their fistulas. Hamilton, *et al.*,<sup>12</sup> have shown that TPN produces an anabolic state and alters the fistulous secretions quantitatively, both of which favor rapid healing and closure.

Another approach, described by Bury, *et al.*,<sup>3</sup> involves the use of a chemically defined liquid

\*From the Departments of Surgery of Englewood Hospital, Englewood, and St. Clare's Hospital, Denville.

elemental diet that provides sufficient carbohydrate, protein, and electrolytes. The elemental composition permits rapid absorption with minimal stimulation of intestinal, biliary, and pancreatic secretions. Over half of the patients with fistulas treated with this form of diet have had spontaneous closure of the fistulas.

Both intravenous hyperalimentation and elemental oral diet play a critical role in the support of these severely ill and depleted patients. Although surgery may be obviated by spontaneous healing of the enterocutaneous fistulas in many patients there are circumstances under which these fistulas persist despite adequate supportive therapy. Concerted preoperative management and a well-timed and well-planned operative approach best serve the patient. The highest percentage of cures results from a definitive operation on the fistula itself with primary resection and end-to-end anastomosis.<sup>4, 9, 14</sup>

### Preoperative Management and Operative Approach

Once the fistula is localized by fistulogram, large and small-bowel contrast studies are performed in all our patients to delineate other internal fistulas or complicating factors such as intra-abdominal collections or distal obstruction.

The composition of our standard hyperalimentation solution for adults (Table 1) consists of 20 to 25 percent dextrose, 4 to 5 percent crystalline amino acids, and 1 to 3 percent multiple vitamins and minerals. Initially 2500cc per day is infused, with gradual increments of 700cc per day to a level of 5000 to 7000cc per day. If diabetes is a complicating feature initial therapy is 1000cc per day with increments of 500cc every five to seven days. Insulin coverage is strictly observed.

Serum electrolyte and fasting blood sugar levels are obtained daily; additional sodium, potassium, chloride, and calcium are added according to the laboratory results. Most of our patients were noted to have above-average potassium requirements due to intracellular

Table 1

500 ml. 8.5% Fraemine II\*

500 ml. 50% plus dextrose

Aseptic mixing with transfer apparatus

To each liter of solution, the following are added:

Sodium (acetate and/or chloride)	40-50 mEq.
Potassium (acetate, chloride, lactate)	20-40 mEq.
Magnesium (sulphate)	8-15 mEq.
Phosphate (potassium acid salt)	12-18 mMol.

Additions to one liter daily

One ampule multivitamins

Calcium gluconate 4.8-9.6 mEq.

Vitamins K, B12, Folic acid and Iron are added to the solutions (or given intravenously in the appropriate dosage daily or weekly)

Trace elements such as copper, cobalt, zinc and manganese are found in fresh frozen plasma which is given once or twice weekly.

\*Each liter contains:

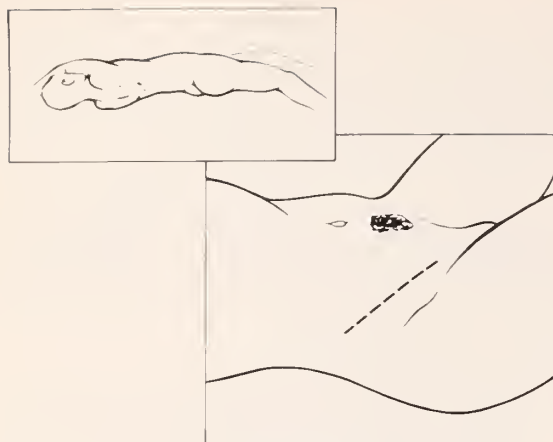
a) 1000 KCal

b) Amino Acids:  $42 \pm 5$  G

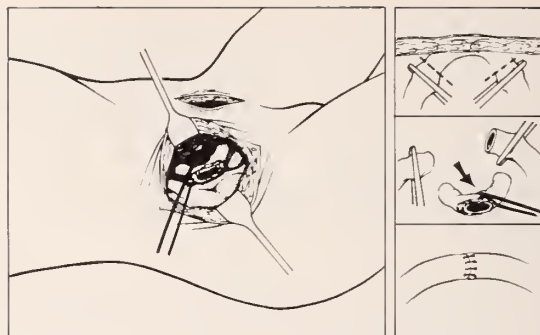
potassium shifts. As much as 200 to 250 meq of potassium chloride were needed per day. Observations included an accurate record of intake and output, fractional urine tests for glucose every six hours, and body weight. Prior to operation antibiotic bowel preparation is instituted and a long intestinal tube inserted to aid in identification of proximal and distal bowel limbs at operation. The role of oral antibiotics in the preoperative treatment of experimental gastrocolic fistulas has been noted<sup>13</sup>.

### Operative Treatment

The operative approach utilized in our patients with enterocutaneous fistulas has been mentioned only casually in the literature. In our modification of the operation, the incision, which is made in an oblique manner through that portion of the abdomen opposite the fistulous opening, splits the oblique abdominal musculature including the rectus when necessary (Figure 1). The incision extends from a point midway between the anterior superior iliac spine and the costal margin obliquely toward the infraumbilical area. After entering the peritoneal cavity adhesions are lysed, and the bowel loop in question, with its fistulous communication, readily can be seen from this lateral approach to be adherent to the anterior



*Figure 1:* The positioning of the patient is indicated with the oblique incision extending from a point between the costal margin and anterior superior iliac spine toward the pubic symphysis.



*Figure 2:* The bowel and fistulous tract have been excised from the anterior abdominal wall; the inserts demonstrate the technique employed for resection and primary end-to-end anastomosis.

abdominal wall. Insertion of catheters into the fistulous opening at operation is an additional aid in isolating the loop. The bowel loop, together with its fistulous tract and accompanying granulation tissue, is then dissected from the abdominal wall leaving a defect in the anterior abdominal wall. At this point the bowel containing the fistula is excised and an end-to-end anastomosis performed. The operative incision is closed to the level of the fascia and the skin and subcutaneous tissue are packed. (Figure 2) The wound thus is allowed to heal by delayed closure or secondary intention. The defect in the anterior abdominal wall which was the site of the previous fistula is closed by multiple through-and-through-retention sutures. If these wound edges cannot be approximated then the wound can be packed over a rubber dam or silastic sheet.

### Discussion

Edmunds and Welch<sup>9</sup> noted that surgical complications account for over 80 percent of gastroduodenal, 70 percent of small bowel, and about 45 percent of large bowel fistulas. The mortality rates were 62, 54 and 16 percent respectively. The most common causes were anastomotic failure, surgical injury, and gross surgical error. Distal obstruction, inflammatory diseases of the large and small bowel, and underlying neoplastic disorders less frequently led to fistula formation. Morbidity, as well as mortality, is related to the level of the fistula,

i.e., the higher its level in the gastrointestinal tract, the more profuse the drainage with proportionally greater loss of fluids, electrolytes and proteins. Therefore, gastroduodenal and high small-bowel fistulas more frequently are complicated by electrolyte deficiencies and severe malnutrition as indicated by total serum protein less than 4.8 grams and/or weight loss greater than 25 pounds. The output from lower small-bowel and colonic fistulas is much less; the complications at this level usually are due to wound infection or of intra-abdominal purulent collections. The severe skin problems encountered in upper intestinal fistulas are usually not a major problem with lower small-bowel or colonic fistulas.

Because of the high morbidity and mortality associated with intestinal fistulas, it is apparent that all efforts should be directed toward preventing such a complication. Careful entry into the abdominal cavity, meticulous intestinal anastomosis with adequate blood supply and without tension at the suture line, relief of distal obstruction, and carefully placed sutures closing the peritoneal cavity will reduce substantially the possibility of this complication. Great care must be exercised in deciding to perform an intestinal anastomosis or exteriorization within a contaminated peritoneal cavity.

Treatment of the patient with an established small-bowel fistula documented by contrast



studies includes: (1) immediate repletion of electrolytes, proteins, calories, and vitamins to reverse the catabolic state, (2) control of infection, (3) local skin care, and (4) relief of any distal obstruction.

The skin is best protected by aluminum paste or karaya gum powder together with frequent dressing changes and sump suction alongside the fistulous tract. Infection is controlled by systemic antibiotics and drainage of localized collections of purulent material.

### Hyperalimentation

Hyperalimentation can correct fluid, electrolyte, and protein losses. Our patients were prohibited from any oral intake and the hyperalimentation solution was infused under aseptic conditions. Therapy was initiated at 2000cc daily with increments up to 6000cc daily. As others have noted,<sup>12</sup> the amount of fistulous drainage dropped rapidly soon after institution of this regimen and this made fluid and electrolyte replacement and skin care considerably easier.

The potential complications of hyperalimentation have been noted by others<sup>6-8</sup>. Dehydration due to hyperglycemia and glycosuria can occur easily if the rate of administration is not monitored carefully, and this may lead to a secondary hyperosmolar state. Diabetics are particularly prone to such difficulties. Measures to counteract this tendency include strict monitoring of infusion flow rates and blood and urine glucose levels. Insulin should be administered as needed, and potassium chloride should be added to the solution if necessary. Finally, reduction of the total fluid delivered daily to allow the pancreas to re-equilibrate at a lower stress level may be needed. One of our patients was repeatedly started on hyperalimentation but each time developed a hyperosmolar state, despite careful monitoring; it was necessary to abandon this modality of therapy.

Sepsis secondary to indwelling subclavian catheters occurs at times. Simple removal of the catheter and replacement with a new catheter on the opposite side usually corrected the

problem and the temperatures returned to normal within twenty-four hours. In those patients, blood cultures and culture of the catheter tip usually grew out *Candida albicans*. This complication occurs at times despite frequent dressing changes about the catheter and replacement of intravenous tubing every two days.

Where a strict hyperalimentation regimen was possible, the patients gained weight, serum electrolytes returned to normal, fistulous output decreased, and wounds healed. None of the fistulas in our experience closed spontaneously without therapy.

Fistulas that persist after an adequate trial of hyperalimentation require surgical intervention. Factors contributing to the persistence of fistulas include size, additional internal tracts, infection, occult neoplasm or foreign body at the origin of the fistula, distal obstruction, granulomatous disease, radiation enteritis and epithelialization of the fistulous tract.

Operations that have been used definitively to correct enterocutaneous fistulas include complete bypass, turn-in of the fistula, and primary resection with end-to-end anastomosis. The latter has been universally shown to be superior to other procedures. Turning in of the fistula is to be condemned. The lateral approach, through a separate clean incision provides ready access to the pathology under direct vision which reduces the possibility of further injury to the bowel.

### References

1. Bacon H, Gennara A: The diagnosis and management of intestinal fistulas. *Dis Colon Rectum* 12:7, 1969
2. Bowlin JW, Hardy JD, Conn JH: External alimentary fistulas. Analysis of seventy-nine cases, with notes on management. *Am J Surg* 103:6, 1962
3. Bury KD, Stephens RV, Randall HT: Use of a chemically defined liquid, elemental diet for nutritional management of fistulas of the alimentary tract. *Am J Surg* 121:174, 1971
4. Chapman R, Foran R, Dunphy JE: Management of intestinal fistulas. *Am J Surg* 108:157, 1964
5. Colcock BP, Braach JW: *Surgery of the Small Intestine in the Adult*. Philadelphia, Saunders, 1968

6. Dressner SA, O'Grady WP, Thorbjarnarson B: Parenteral hyperalimentation and multiple gastrointestinal fistulas. *NY J Med* 71:665, 1971
7. Dudrick SJ, Wilmore DW, Vars HM, Rhoads JE: Long-term total parenteral nutrition with growth, development, and positive nitrogen balance. *Surg* 64:134, 1968
8. *Idem*: Can intravenous feeding as the sole means of nutrition support growth in the child and restore weight loss in an adult? An affirmative answer. *Ann Surg* 169:974, 1969
9. Edmunds LH, Williams GM, Welch CE: External fistulas arising from the gastrointestinal tract. *Ann Surg* 152:445, 1960
10. Filler RM, Eraklis AJ, Rubin VG, Das JB: Long-term parenteral nutrition in infants. *N Engl J Med* 281:589, 1969
11. Halversan, RC, Hogle HH, Richards RC: Gastric and small bowel fistulas. *Am J Surg* 118:968, 1969
12. Hamilton RF, Davis WC, Stephenson DV, Magee, DF: Effects of parenteral hyperalimentation on gastrointestinal tract secretions. *Arch Surg* 102:348, 1971
13. Jew EW, Levowitz BS, and Fisher B: Alteration of the effects of jejunocolic fistulas: An experimental study. *Ann Surg* 155:175, 1962
14. Lorenzo GA, Beal JM: Management of external small bowel fistulas. *Arch Surg* 99:394, 1969
15. McGovern B: Intravenous hyperalimentation. Surgical Service, Wilford Hall USAF Medical Center, Lackland AFB, Texas, 1970
16. Miller AI, Dorn BC: Postoperative gastrointestinal fistulas. *Am J Surg* 11:382, 1968

1555 Center Avenue, Fort Lee

### Hemorrhoids Treated Successfully by Simple, Inexpensive Procedure

Hemorrhoids can be removed safely and effectively by ligation with rubber bands at a cost of \$175 instead of by conventional surgery at an average cost of \$1,400, says a report in the April issue of the *Archives of Surgery*, a scientific publication of the American Medical Association. Not only is the cost less, but the hospital stay of several days and the acute postoperative pain and discomfort is virtually eliminated, says John Bartizal, M.D., and P. A. Slosberg, M.D., of Loyola University, Chicago.

Ligating hemorrhoidal tissue by rubber bands has been used for 20 years as an alternative to regular surgery, they point out. The rubber band at the base of the hemorrhoid cuts off the blood supply, and the tissue sloughs off in a few days.

The Chicago doctors gave the technique a thorough test. Their report is a review of 670 patients who underwent 3,208 rubber-band ligations for internal hemorrhoids. Mild to moderate discomfort occurred in 32 patients,

while pain severe enough to limit activity occurred in only four patients. Slight bleeding was noted in 19 patients and severe bleeding in nine. Only two of these nine required hospitalization and further treatment.

The bands were placed by an instrument used in the doctor's office. Most patients required six bandings for multiple hemorrhoids, and 98 percent of the patients got rid of their hemorrhoids with no complications sufficient enough to interfere with daily activity.

"Rubber-band ligation of hemorrhoids meets all the requirements of an acceptable alternative to hemorrhoidectomy, and considering convenience, comfort, and cost, it may well be a superior alternative," say the authors.

The \$1,400 average cost of conventional surgery includes the physician's fee, hospital charges, and laboratory and x-ray charge. The \$175 cost for banding includes six bandings and proctoscopic examination.

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<sup>1</sup> Goth, A. Medical Pharmacology, Principles and Concepts, ed 7. St. Louis, C. V. Mosby Company, 1974, p. 455.

<sup>2</sup> Schneider, R. P., and Roach, A. C. An Antacid Tasting: The Relative Palatability of 19 Liquid Antacids. South Med J. 69: 1312-1313 (Oct.) 1976.

### PRO-BANTHINE®

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**Indications:** Pro-Banthine is effective as adjunctive therapy in the treatment of peptic ulcer.

Based on a review of this drug by the National Academy of Sciences - National Research Council and/or other information, FDA has classified the other indications as follows:

Probably effective as adjunctive therapy in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis, acute enterocolitis, and functional gastrointestinal disorders).

Final classification of the less-than-effective indications requires further investigation.

**Contraindications:** Glaucoma, obstructive disease of the gastrointestinal tract, obstructive uropathy, intestinal atony, toxic megacolon, hiatal hernia associated with reflux esophagitis, or unstable cardiovascular adjustment in acute hemorrhage.

**Warnings:** Patients with severe cardiac disease should be given this medication with caution. Fever and possibly heat stroke may occur due to anhidrosis.

In theory a curare-like action may occur, with loss of voluntary muscle control. For such patients prompt and continuing artificial respiration should be applied until the drug effect has been exhausted.

Diarrhea in an ileostomy patient may indicate obstruction, and this possibility should be considered before administering Pro-Banthine.

**Precautions:** Since varying degrees of urinary hesitancy may be evidenced by elderly males with prostatic hypertrophy, such patients should be advised to micturate at the time of taking the medication.

Overdosage should be avoided in patients severely ill with ulcerative colitis.

**Adverse Reactions:** Varying degrees of salivary secretions may occur as well as dryness and blurred vision. In addition the following adverse reactions have been reported: drowsiness, dizziness, insomnia, headache, loss of the sense of taste, nausea, vomiting, constipation, impotence and allergic dermatitis.

**Dosage and Administration:** The recommended daily dosage for adult oral therapy is one tablet with meals and two at bedtime. Subsequent adjustment to the patient's requirements and tolerance must be made.

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*A technique of rectal fistula setonization is described. Three areas of use are enumerated and an explanation is offered for the method of destruction of the abnormal passage.*

# The Seton in Fistula Surgery

**Salvatore J. Detrano, M.D., Union City\***

The complicated fistula is probably the most difficult benign condition affecting the anus and rectum with which the surgeon must cope, so any addition to treatment methodology is certainly most welcome.

The seton is a tool which deserves review. As used here, the seton is a malleable filiform material (either thread or wire) passed through a fistula tract and used to identify a fistula or to aid in the excision of a passage in definitive fistula surgery.

Pennington<sup>1</sup>, in 1907, used a rubber band which was tightened by the patient. Allen and Haskell<sup>2</sup> reported 266 cases and found the seton a valuable procedure. Buie<sup>3</sup>, in 1927, used a heavy thread that he gradually tightened. Gorsch and Becker<sup>4</sup> described a seesaw motion with a knotted #4-0 steel wire to cut through the muscle. Hyman<sup>5</sup>, in 1955, followed Gorsch's method using a stainless braided #000 steel wire and reported five cases. Fansler<sup>6</sup>, in 1956, mentioned the seton for extensive fistulas. Smith<sup>7</sup> found it "advantageous only in infants, where surgery and postoperative care are impractical."

## Mechanics of the Seton Technique

The following description of the mechanics of the seton is most interesting:

"Taking a very slender thread of raw lint, and uniting it into five folds of the length of a span, and wrapping them round with a horsehair. Then having made a director of tin, with an eye at its extremity, and having passed through it the end of raw lint wrapped round as above described, introduce the director into the fistula, and at the same time, introduce the index finger of the left hand per anum; and when the director touches the finger, bring it out with the finger, bending the extremity of the director and the end of the threads in it, but the ends of the thread are to be knotted twice or thrice, and the rest of the threads are to be twisted round and fastened into a knot. Then the patient is to be told that he may go and attend to his matters."

That description was written by Hippocrates<sup>8</sup> in approximately the year 400 B.C.

The essential equipment for setonization consists of an anoscope, preferably with a beveled distal end, a straight probe such as a Barr probe with a hole at the distal end, a curved probe also notched at the distal end to permit a wire or thread to be tied in place, and a braided tantalum wire used for cutting and soft enough not to cause discomfort. (Figure 1). The Barr probe with the wire threaded is placed through the fistula and protrudes at the internal opening. With the anoscope in place, one end of the wire is grasped with a clamp and brought out through the anus. (Figure 2). The probe is withdrawn and with it the other end of the wire. Both ends are then loosely tied.

There are three primary uses for the seton: (1) preoperatively to facilitate surgery, (2) during surgery and postoperatively to exteriorize the tract, and (3) rectovaginal fistula.

## Fistula Surgery with the Seton

One of the very disconcerting experiences a surgeon can have is to search in vain for an internal fistula opening at the time of surgery. This can lead to the most common cause for recurrence, i.e., the inadvertent puncturing of the rectal mucosa in a location other than the true internal opening and then proceeding with the surgery under the impression that he has the complete tract. Preoperative setonization with heavy silk thread (as an office procedure) eliminates this possibility. Then at surgery one merely excises the tract around the seton, following which satisfactory saucerization is possible. The patient is almost assured a cure. This technique also has been applied successfully by the author<sup>9</sup> to cryosurgery of fistulas.

\*Dr. Detrano is Director of Proctology, Christ Hospital Jersey City.



Figure 1



Figure 2

In the case of an extensive fistula, whether it be of the high level or the horseshoe type, the surgery is conducted in the usual manner. The tract, however, is excised up to but not through sphincteric muscles and loosely tied outside the anus. About two weeks later, when sufficient healing has taken place to fix the muscles in position, the wire is seesawed through part of one muscle, (Figure 3).

Several days later the procedure is repeated *through* the remainder of that muscle and part of the next. This eliminates the possibility of muscle retraction. It is repeated again until the tract is completely exteriorized. I find an injection of a local anesthetic into the muscle to be very helpful. Excessive bleeding is not encountered. By this method one may prevent incontinence and some of the deforming defects so often seen with extensive one-stage fistulectomy.

The seton has been very valuable also in the treatment of rectovaginal fistula. In this condition, it is essential that the anterior portion of the subcutaneous external sphincter and the perineal body be strong and intact. As in the case of the extensive fistula, the tract is exteriorized in stages. Cogan and Harris<sup>10</sup> reported rectoperineal and rectovaginal fistulas satisfactorily treated with "string technique" as a modified seton.

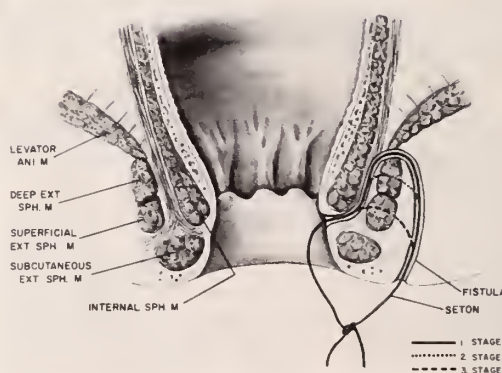


Figure 3

It seems that the success of this procedure depends on two factors. First, the seton must remain following initial insertion long enough to permit an inflammatory process to set in and destroy the fibrotic lining of the fistula; this appears to coincide with the time it takes for a well-saucerized area to granulate. Second, the muscles are cut in such a manner that separation does not take place.

## References

1. Pennington JR: *Rectum and Anus and Pelvic Colon*. Philadelphia, Blakiston Co., 1908, p. 619.
2. Allen JH, Haskell B: Two-stage operation for fistula-in-ano. *Surg Gynec and Obstet* 58:651, 1934.



3. Buie IA: Origin and treatment of fistula-in-ano. *Surg Clin N Amer.* 7:1579, 1927.
4. Gorsch RV, Becker GI: Pathogenesis and treatment of extensive atypical ano-rectal fistulas. *Am J Surg* 79:203, 1950.
5. Hyman C: Use of braided wire seton for two-stage anorectal fistula operation. *Arch Surg* 77:890-891, 1955.
6. Fansler WA: Cause and care of extensive rectal fistulas. *Texas State J Med* April 1956.
7. Smith ND: Anorectal abscesses and fistulas. *So Med J* 49:78, 1956.
8. Adams F: *The Genuine Works of Hippocrates*. New York, William Wood and Co. 1929.
9. Detrano SJ: Role of cryosurgery in management of anorectal disease. *Dis Rect and Colon* 18:119, 1975.
10. Cogan JE, Harris JW: Rectal complications after perineorrhaphy and episiotomy. *Arch Surg* 93:635, Oct. 1966.

1800 Hudson Boulevard, Union City

## Sexual Revolution Reflected in Medical Practice in U.S.

The so-called sexual revolution of the past 10 to 15 years is real, America's doctors report. Two-thirds of primary care physicians, responding to an AMA poll, declare that the sexual revolution has been "markedly reflected" in their day-to-day office practice.

The doctors report an increase in requests for information on birth control and abortion, more incidence of venereal disease, and more requests for help with sexual problems.

Results of the poll are published in the April 25 Impact Section of *American Medical News*, the AMA's weekly newspaper for physicians. Doctors polled included general and family practitioners, internists, obstetricians-gynecologists, and pediatricians.

Some of the doctors report they are seeing more sexually-related infections and diseases. Many more female patients are now taking the birth control pill. More requests are being received for sterilization, and doctors are being asked about sex after heart attacks. Teenagers are less reluctant to be examined than in the past, and there are more births to younger parents. More teenagers ask for sexual counseling. Almost half of the physicians in the poll say that patients are asking for sexual counseling much more frequently in recent years.

How competent are physicians in dealing with sexual problems of their patients? Two out of three report they do not believe their medical education equipped them adequately. Doctors under 35 report more training in sexual counseling, indicating that medical schools have begun in recent years to devote more time to the area. But 90 percent of the respondents declare that medical schools should devote even more time to sexual training.

What do the doctors think of the sexual revolution? Indications are revealed in their candid comments in the poll:

"It's a good thing" . . . "Healthy" . . . "An overdue adjustment to sexual reality."

"It's tragic" . . . "Disgusting" . . . "A bummer."

"It's no revolution. People just talk more about sex."

"It has appreciably increased venereal disease and disrupted the family complex."

"It's a good change. We were too puritanical."

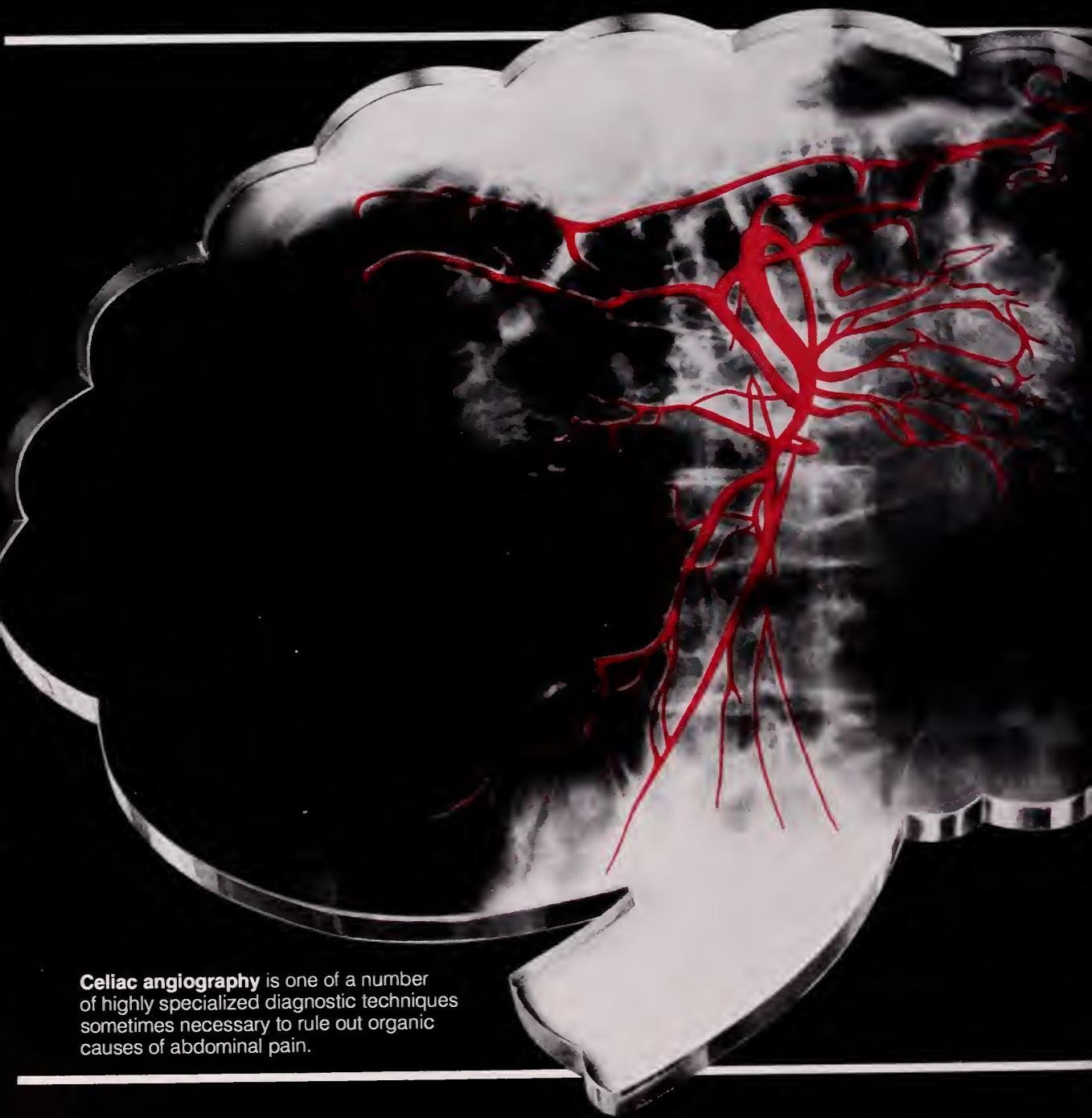
"It's a serious mistake that has shaken the whole moral fiber of the nation."

"The openness and willingness to discuss sexual problems is good."

"It's a return to paganism."

"Vive la revolution!"

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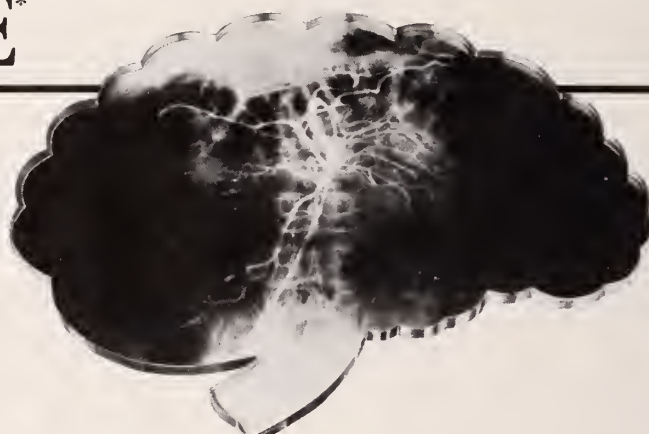


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Please consult complete prescribing information, a summary of which follows:

\* **Indications:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

**Contraindications:** Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide hydrochloride and/or clidinium bromide.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium® (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

**Usage in Pregnancy:** Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

As with all anticholinergic drugs, an inhibiting effect on lactation may occur

**Precautions:** In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacologic effects of agents, particularly potentiating drugs such as MAO inhibitors and

phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

**Adverse Reactions:** No side effects or manifestations not seen with either compound alone have been reported with Librax. When chlordiazepoxide hydrochloride is used alone, drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are avoidable in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, i.e., dryness of the mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

**Dosage:** Individualize for maximum beneficial effects. Usual maintenance dose is 1 or 2 capsules, 3 or 4 times a day, before meals and at bedtime. Geriatric patients—see Precautions.

**How Supplied:** Librax is available in green capsules, each containing 5 mg chlordiazepoxide hydrochloride (Librium®) and 2.5 mg clidinium bromide (Quarzan®)—bottles of 100 and 500; Tel-E-Dose packages of 100; Prescription Packs of 50, available singly and in trays of 10.

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*Methadone, as currently employed, has a significant place in the treatment of drug addiction. We prefer to use the term methadone treatment or support rather than maintenance in view of our treatment goals, although we recognize that some patients will require long-term maintenance. Methadone is an addictive drug and not a cure, but it does provide a respite and an opportunity for patients to change if they wish. Some patients may do well in therapeutic communities, drug-free counseling programs, or with the help of narcotic antagonists but these, unfortunately, make up a small proportion of the patients. For the rest, who are either unwilling or unable to profit from these programs or who have attempted them and been unsuccessful, methadone treatment provides a reasonable alternative to increasing heroin tolerance, life on the streets, and continuing criminal activities to support their habits.*

## Common Questions About Methadone Treatment

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**Edward Gottheil, M.D., Ph.D.**  
**Philadelphia**

Prospective patients, their families and friends, teachers, probation officers, and other community workers frequently ask many of the same questions about the use of methadone in the treatment of narcotic addiction. Some of these include: Why treat an addiction to one narcotic with another narcotic? Do methadone clinics make addicts out of unaddicted children who apply for treatment? What harmful effects does methadone have on the body? What steps are taken to keep methadone from being diverted to the black market? Is anything done for addicted patients at these clinics besides giving them methadone? What are the goals of methadone treatment? Does it work?

Since answers to these questions are not readily available in medical and psychiatric textbooks, medical students, residents, and practicing physicians often ask the same questions. Indeed, the questions have come so frequently that we found it useful to prepare a mimeographed handout in which the 13 most common ones were discussed. Before turning to our list of questions, however, it might be helpful to provide some perspective by briefly reviewing the history of drug treatment in this country.

### History of Drug Treatment

During the early 1800's, there were few drug addicts and these were generally cared for by

private practitioners. Treatment at that time usually involved little more than helping the patients through withdrawal when this was requested<sup>1</sup>. The widespread use of morphine during the Civil War resulted in many more cases of addiction but most were easily and successfully withdrawn. The few that remained addicted were not seen as a major problem since morphine was easily available. However, many other people were becoming addicted in the middle and late 1800's through the use of opium-containing patent medicines. When heroin was developed in 1898, it was found capable of relieving morphine withdrawal symptoms and was hailed as a cure for morphine addiction. Shortly thereafter, it was learned that heroin was no less addicting than morphine and created even more problems<sup>2</sup>. Parallels have been drawn between this experience with heroin and the current experience with methadone.

It was not until the turn of the century that drug addiction emerged as a public health issue. The number of cases, including a significant proportion of physicians, was steadily increasing. It had become apparent that treatment would require more than simple withdrawal, that complex psychological factors

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\*This work is from the Department of Psychiatry and Human Behavior, Jefferson Medical College of the Thomas Jefferson University, Philadelphia, Pennsylvania, and was supported in part by the Department of Health, Education and Welfare Public Health Service Grant 5-H80-DA-00996.



were involved so that people of all socioeconomic classes and backgrounds could be affected, and there was a pronounced tendency for relapse, recurrence, and chronicity. Finally, the Harrison Act was passed in 1914 to restrict and control the distribution of opiates and cocaine. Thus, following World War I, which again resulted in many new medically addicted individuals, legitimate sources of narcotics were no longer available. Addicts turned to the black market and organized crime flourished. The Federal Government responded by encouraging and supporting the establishment of 44 clinics designed to provide maintenance medication followed by dose reduction and withdrawal. A few of the clinics had some success, most merely offered maintenance, and illegal diversion became a major problem. Federal support was withdrawn and by 1925 all of these clinics had closed. The lack of treatment facilities resulted in many patients ending up in federal prisons. In the middle thirties, federal institutions were opened at Lexington and Fort Worth for the treatment of federal prisoner drug addicts. Later, voluntary patients also were accepted. Different treatment approaches were attempted, some extending for considerable periods of time, but follow-up data consistently revealed poor results. Nevertheless, these were the only available treatment facilities until 1952 when Riverside Hospital in New York attempted to treat juveniles who were involved with drugs. Although this program was treating younger and less chronically addicted patients and often included hospitalization for 18 months and more, follow-up results still revealed a 95 percent relapse rate. The program was discontinued in 1963.

The explosion in drug addiction during the fifties and sixties led to a search for new treatment approaches. Synanon, founded in 1959, provided a model therapeutic community residential program emphasizing the psychological aspects of addiction and self-help techniques. Many similar communities were formed and they have become recognized as an important treatment resource. Although there have been some successes, the problem with this approach is that few patients wish to enter such communities. Of those who apply, few

make it through the demeaning and rigorous initiation procedures and, of those who do, 75 percent leave within the first month.<sup>3</sup> In the early sixties, both California and New York established statewide treatment programs offering withdrawal, a period of mandatory hospitalization, psychiatric treatment, group therapy, and compulsory aftercare. Again, treatment results were disappointing.

In 1965, Dole and Nyswander noted that while high doses of methadone blockaded the effect of heroin, their patients still could function normally and not experience the highs, euphoria, somnolence, or motivationless states common with heroin. Consequently, they recommended methadone as a medical treatment for heroin addiction.<sup>4,5</sup> A 1967 independent evaluation of a methadone maintenance program, which included individual counseling and support services, revealed that 80 percent of the patients were retained in the program and that the social functioning of these patients had improved.<sup>1</sup> Recently, there have been many attempts to develop effective narcotic antagonists. Programs using these antagonists, however, have not enjoyed wide success with many patients as the antagonists are either too short-acting or have unpleasant side effects. The search for a long-acting drug without side effects persists.

## Questions and Discussion

Most current treatment programs employ as many of the above methods as possible and attempt to adapt the treatment plan to the particular patients. There have been no significant breakthroughs and no clear-cut solutions. It is against this background that we wish to discuss the following questions that have been raised about methadone.

*1. Why treat addiction to a narcotic drug like heroin with another narcotic drug like methadone?*

There are some basic differences between the two drugs. The effects of heroin last four to five hours and the amount of drug necessary to keep an individual from becoming uncom-



fortable increases very quickly. Therefore, almost as soon as he has obtained a "fix" he needs to look for funds for his next one. This takes more and more drug and more and more money and soon comes to occupy nearly all of his time as he is caught on a treadmill going from fix to fix. Methadone lasts about 24 hours; the patient can remain comfortable on the same dosage and it is available at a methadone clinic free. If methadone is substituted for heroin, then, the patient can stop stealing to support his habit. If he wishes he can work or go to school, spend time with his family, regain some self-respect, and start thinking again about the possibility of changing his life style.

## *2. Does methadone treatment require so much drug that the patient is turned into a zombie?*

When methadone maintenance treatment was first started, large doses were used because such amounts would block the effects of heroin. Even if the patient took heroin in addition to his methadone he would feel little or no effect from it. The higher the dosage of methadone, the greater the amount of heroin required to overcome the methadone-blocking effect. Even at these doses, few patients experienced highs or lethargy. Highs do occur on methadone but require extremely high oral doses or intravenous injection. As the use of methadone treatment spread, experience increased, the goals of treatment changed, and the amounts of methadone given were greatly reduced. At the present time only enough is given to keep the patients from becoming uncomfortable. When the dose is properly adjusted at these levels (20 to 80 mg daily) it does not interfere with thinking, it does not produce highs, it does not result in sleepiness, and it still prevents drug craving and withdrawal effects.

## *3. What are the harmful effects of methadone on the body?*

Patients addicted to narcotic drugs often do not eat or dress properly, they sleep irregularly and generally do not take care of themselves. They become run down, their resistance decreases and they may develop infections, poor teeth, and so on. When they inject drugs with

improper or poorly cleaned equipment, they may develop skin abscesses, scarred veins, liver disease, or other complications. Although these patients require a great deal of medical attention, the problems are all side effects. No harmful effects on the brain or other parts of the body have been found when methadone is ingested on a regular schedule—even when taken in large amounts for many years.

## *4. What are the goals of methadone treatment?*

Briefly stated, in order of increasing accomplishment, they are as follows: to help someone escape from his need to commit crimes to support his habit by providing methadone; to examine him medically and provide necessary care and treatment; to engage the patient in individual and group counseling sessions and encourage reliability in keeping regular appointments; to provide vocational, educational, and family counseling and guidance directed toward the return to his family and school or job; to help the patient review his life style, set goals and work for them, gain self-respect and learn to work with his problems; to reduce dependence on methadone and become drug-free; and to continue treatment after he has become drug-free until he feels ready and able to function in society without the support of the program. While all patients do not progress uniformly through this list of goals, the objective of the clinic is to help them move as far along in the hierarchy as possible.

## *5. Can patients with a drug problem obtain methadone treatment from any physician?*

While any physician may prescribe methadone when medically indicated, only physicians with a special license are allowed to provide methadone treatment for addicted patients and only at clinics which are approved by the government. To be approved, these clinics must meet strict government standards which include:

- a. Proper number and type of staff.
- b. Availability of other medical treatments.
- c. Safeguarding of methadone.
- d. Completeness and accuracy of reports and records.

The clinics are inspected frequently to be sure that they maintain such standards and procedures and keep complete and accurate records.

*6. How are patients protected so that they will not become known to the government as drug addicts or be listed on police or other official records?*

It is extremely important that patients feel safe in coming for treatment and the regulations, therefore, are very clear about the patients' rights to privacy. They state that no information may be given out about a patient without his written permission—not even that he is a patient or that his name is known to the clinic—except under three conditions. First, information may be given to other doctors when it is necessary to help them treat the patient for a medical condition or emergency. Second, the records of the program may be seen by clinic program inspectors but these persons, by law, must not in any way identify any patients in any report to anyone. Their job is to inspect the program, not the patients. Third, information may be obtained by a special court order under circumstances not related to drugs. This is done very rarely. In the many years that one program known to the author has been operating, information about patients was refused to families, police, probation officers, and the FBI. Not once was there any question of a court order.

*7. What steps are taken to keep methadone off the black market?*

This is clearly an important matter since methadone is a narcotic drug and can be sold for considerable profit. Therefore, it is necessary to safeguard against theft and to prevent patients and others from obtaining a supply for sale. The government is very specific about the construction of the clinic, special doors and locks and the type of safe that may be used for storing methadone. Burglar-alarm systems for the safe and the clinic must be installed and connected with a police or private agency monitoring system. Records must be kept of the amount of methadone delivered, the amount

given to patients and the amount on hand. Each dose must be accounted for. There also are special rules for how shipments of methadone are made, who may do this, what records are kept, and so on. The methadone that is given to patients is in a form to be taken by mouth and is prepared in such a way that it is very difficult to change so that it could be injected. New patients are required to come and take their methadone at the clinic seven days a week. In addition, urines of the patients are checked on a random basis to see whether they have taken their methadone and that they have not taken other drugs. Only after they have done well (kept regular appointments, committed no crimes, taken no illegal drugs, made progress in counseling sessions, obtained a job, and so on) for at least three months are they given any take-home methadone.

*8. Is every patient who applies to a methadone program accepted for treatment?*

The admission requirements for a methadone treatment program are that the patient be at least 18 years old, have a history of dependence on narcotic drugs for at least two years, show certain medical signs and symptoms of withdrawal when he does not receive drugs, present other evidence of addiction such as positive urine tests, old and fresh needle marks and information about his addiction from other sources, and, finally, be likely to benefit from treatment in the professional judgment of the medical director. If a patient is between 16 and 18 years of age he may be admitted if, in addition to all of the above requirements, his parents or guardian sign a consent-to-treatment form with him and present evidence that there have been at least two previous unsuccessful attempts to help him become free of drugs. No patient under the age of 16 may be admitted to a methadone program.

*9. How does a patient enter a methadone treatment program?*

Treatment in a methadone program is always voluntary. When a patient applies to a clinic he is given a consent form which describes the program. The program is then discussed and

explained in detail before he signs the consent form which is also his application to enter the program. He is informed that the program involves taking methadone daily and that methadone is a narcotic drug which is addictive and can be harmful. He is made aware that there are outpatient and live-in drug-free treatment programs to which he may be referred, and that he can be helped to withdraw from drugs slowly and comfortably under medical supervision. If, after recognizing the disadvantages of methadone treatment and learning about the availability of drug-free programs, he still wishes to apply for methadone treatment, it is explained that the goals of this treatment also include helping him with his problems, providing school or job guidance, training and counseling, and reducing dependency on drugs to achieve a drug-free state.

*10. What if a patient wishes to leave the program before the staff feels he is ready?*

The consent form which the patient signs when he enters the program states very clearly that he is free to withdraw from the treatment program at any time. If he decides to do this, even against medical advice, he will be helped to decrease the amount of methadone slowly under medical supervision so that the withdrawal will not be difficult or uncomfortable and will be referred to other drug-free programs if he wishes it.

*11. Is it more difficult to withdraw from methadone than heroin?*

This is a common misconception. Since methadone remains in the body for a longer time than heroin, withdrawal does take longer. However, the symptoms are not more severe and, in fact, are often less severe. Actually, withdrawal from any of the narcotic drugs under medical supervision is not difficult or really uncomfortable.

*12. What is done for addicted patients at methadone clinics besides giving them methadone?*

As previously indicated, all approved programs must have many resources available to them including: complete medical workup and treatment, individual counseling, group counseling, vocational guidance and assistance, educational guidance and assistance, family counseling.

*13. Does methadone treatment work?*

The results of methadone treatment compare favorably with the results of other treatment methods. To begin with, 80 to 85 percent of patients who come to methadone programs return and remain in treatment for considerable periods of time, while 80 to 85 percent of patients who come to other treatment programs leave within the first month. Statistics from methadone treatment programs reveal that the number of crimes committed by patients and the amount of illegal drug use decreases markedly. At most clinics, 30 to 40 percent of the patients are employed, many are slowly reducing the amount of methadone they are taking, and about 5 to 10 percent are drug free but continue to visit their counselors on a regular basis.

## References

1. DHEW Publication No. (ADM) 75-197. *Treatment of drug abuse: An overview*. National Clearinghouse for Drug Abuse Information, Report Series 34, No. 1, 1975, pp. 13.
2. DHEW Publication No. (ADM) 75-198. *Heroin*. National Clearinghouse for Drug Information, Report Series 33, No. 1, 1975, pp. 21.
3. Glasscote R, Sussex JN, Jaffe JH, Ball J and Brill L: The treatment of drug abuse—programs, problems, prospects. Washington, D.C., Joint Information Service, 1972, pp. 250.
4. Dole VP and Nyswander M: A medical treatment of diacetylmorphine addiction. *JAMA* 193:646-650, 1965.
5. DHEW Publication No. (ADM) 74-126. *Methadone: The drug and its therapeutic uses in the treatment of addiction*. National Clearinghouse for Drug Information, Report Series 31, No. 1, 1974, pp. 21.

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*As part of the socialization process of growing up children must learn to handle their feelings and thoughts appropriately. This process occurs within the family system with outside influences from other adults, peers, the community, school, church, and other institutions. Television also plays a major role. This developmental process and the effects of child abuse and neglect on this process are discussed.*

## The Development of Human Aggression\*

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**Larry B. Silver, M.D., Piscataway\***

During the time between infancy and adulthood the child must learn to handle his or her feelings and thoughts appropriately. Certain behaviors are learned to be acceptable and others not. For most children this "socialization" process occurs within the family system with additional influences from other adults, peers, the community, school, church, and other institutions. As will be discussed later, television is another major influence.

The parents' role in this socialization process is critical. Their style of child rearing, discipline techniques, and role models influence the child during the developmental process and shape the adult to be.

To understand this process of moving the child from direct expression of his angry feelings to socially acceptable ways of expressing feelings, one must look at two themes: (1) the normal psychological and social development of a child and the multiple tasks, influences, and coping techniques available at each stage of development; and (2) the dynamics of the family and its multiple roles and influences on the child's development.

Through these two influences the child learns to move from open physical expression of anger to less aggressive acts to the use of words rather than actions and, eventually, to the use of substitute behaviors, thoughts, or passive acts to express anger.

This paper will review these two frames of reference for understanding the child's socialization of aggression, then explore the effects of child abuse and neglect on this process, leading to some explanation of the observed

theme that violence often breeds violence, and finally focus on the possible influences the mass media, especially television, has on the socialization of aggression.

### Normal Psychosocial Development

The new-born infant functions primarily as a physiological being, receiving stimuli from his body and from all his senses and responding. Initially the child is unrelated to anyone and undefined from the environment. As the child perceives the world there is no differentiation between his body and the environment. The baby's stomach hurts; he cries; he is fed, causing the pain to go away; and, he relaxes and sleeps. Any frustration or discomfort is expressed directly and openly. The infant may scream, thrash his arms and legs, and, later, bite.

Gradually the infant begins to discover boundaries. He discovers fingers, hands, toes, and feet and finds that these objects belong to the same body that he has begun to experience. At about three months of life, the infant begins to recognize pieces or parts of the world and relates to these "part objects" as important. We see the social smile; the child looks at part of a face and smiles. By about nine months of age most infants have finalized this process, discovering where they leave off and the world begins. They discover that there are many people-objects in the world. By associating pleasurable experiences with certain of these people-objects the child begins to learn that specific ones are very important. He establishes basic trust in these key people and becomes totally dependent on them. In establishing basic trust in these key parenting people, the

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\*Dr. Silver is Professor of Psychiatry, Professor of Pediatrics, and Chief, Section of Child and Adolescent Psychiatry, Rutgers Medical School, CMDNJ, Piscataway.

infant masters the first major step in psychosocial development. Parents now find that their child becomes upset if they leave; the child has a fear of separation and a fear of strangers.

The child becomes demanding and possessive. If frustrated he may still express anger openly by hitting, scratching, biting, or yelling. Many parents stop their child from hurting himself or others but do not try to block such expressions.

By one year of age most children have established basic trust in significant parenting adults, becoming intimately dependent on them for their total emotional and physical well-being. The next task in psychosocial development is to learn how to separate from these significant people and survive. The child masters this stage of separation in steps, starting at nine to twelve months and usually finishing at three to three and one-half years.

Initially, the child needs some form of perceptual hook-up with the significant person. The baby cries, then hears a parent's footsteps in the hall and stops. The auditory linkage was enough. A child crawls behind a chair, loses sight of a parent and cries, then, as the parent moves into view, stops. The visual linkage reestablished contact. A baby cries at night, is picked up in the dark and held, and stops; the touch and smell provide reassurance of the needed intimate connection. During this phase direct expression of anger is still tolerated by most parents. The child begins to learn that some actions are unacceptable but that others are tolerable.

Slowly, beginning at about 18 to 24 months, the child learns to separate for longer and longer periods of time. Yet, he still must return frequently to the parent to "refuel." A hug or kiss or cookie will do and he is off again. For some children these early efforts at separating are made easier if something reminding them of a parent can go along. These "transitional objects" are usually selected because they have a familiar smell or soft touch, or cuddly feel which they have learned to associate with the parent.

During this second major stage of development, as the child is trying to master separation, two major psychological events take place. Each helps the child master separation and each helps to shape his or her handling of angry feelings and style of expressing anger.

The first of these issues is "negativism" which begins at about age two. Most requests or comments are responded to with a "No. . . ." "No, I can do it myself, ma." The child is beginning to try out having a mind of his own. This negativism is an effort toward mastering the separation process. It is also the beginning of expressing frustration and anger through words rather than actions. A properly timed and defiant "no" can communicate the anger and affect to a parent just as effectively as a hit or kick.

The other issue occurring at about age two is toilet training. In the process of toilet training the child must begin to learn two new concepts. First, the child must shift his concept of love and relationships. Up until this time the whole world was perceived by the child as being there to take care of him. Love and caring were automatic and free. Suddenly the child begins to learn that love is no longer free and available at his every request. Now, if the child wants love he must do something. Loving relationships are no longer totally centered around the child's wishes and needs but are a give-and-take process. "Make in potty and mommy loves you; make in pants and mommy frowns or hits or threatens not to love you." To get love requires giving. To be pleased requires pleasing. This is a major shift in the child's concept of the world, of people, and of relationships, an essential shift for the child to master.

The second new concept introduced with toilet training is that of having aggressive power. For the first time in a child's life he has an active weapon. Prior to this, the child could cry or have a tantrum but the parents could choose whether to respond or to get angry or not. Prior to this the child experienced anger and expressed it. Now the child begins to realize the significance of anger and the influence his way of expressing anger has on getting or keeping



love. Direct expression of anger does not work; the price to pay might be too great. He begins to learn that passive, indirect expressions of anger work as well as hitting or yelling. Now, if angry with a parent he can squat right in front of the parent, preferably when company is around, and with a big smile "make" in his pants. If pleased with mommy or daddy he will "make" on potty. The child begins to learn the importance of controlling anger or of learning more acceptable ways of expressing anger.

These issues—of wishing to please and be pleased, loving and being loved, and handling angry feelings—are struggled with individually and together. The two themes can interrelate; it is possible to love and to hate the same person at the same time or to hurt and care for the same person at the same time.

Pure narcissism is no more. Being held, feeling warm and safe, and sensing total pleasure is no longer there for the demanding. The free expression of anger is no longer accepted. The child learns that he must give to get, must learn how to please to be pleased, and must deal with those feelings created when one does not get what he wants or needs.

If the child has mastered the first major task of development, establishing basic trust, and the second major task, separating, he is ready to struggle with the next task, individuation. This deals with asking and trying to answer the question, "Who am I?" "Now that I've learned that I am a person and that I can survive without these important people, what kind of a person am I?" These questions are struggled with between the ages of three and six.

The child begins to try out many roles. What is it like to be big, little, active, passive, a boy, or a girl? He begins to experience what it is like to be female or male. It is during this time that we imprint our cultural stereotypes of behavior. If a boy reaches for a doll to play with, he is told that boys play with guns not with dolls. This theme is amazing since adult men must know how to relate lovingly to their children and not to use guns. Girls learn that they play

with dolls and do things in kitchens; they do not use guns or work with tools in shops. Boys learn that it is acceptable to express anger but not love or sadness; girls learn the opposite. Fortunately, the consciousness-raising efforts of the women's liberation movement have helped to free us from these stereotypes. Children should feel free to explore and to learn many roles in becoming a male or female. They should learn that the concept of maleness or femaleness is not based on the kinds of things one does or how one expresses different emotions but on the kinds of experiences, relationships, and respects one develops toward others.

During this stage of development the child begins to explore the differences between boys and girls and to notice these differences. While playing "house" or "school" or "doctor" he explores various roles and differences. One day the child is a boy, the next day he is a girl or a mommy or a daddy or a teacher.

The boy may become very affectionate with mother or the girl with father; loving glances while cuddling or kissing reflect this affection. They begin to want to have total possession of this significant parent. They begin to learn how to split their parents or to manipulate the environment in order to get this person for themselves. Once again they must deal with love and anger, often at the same time. Parents begin to teach the child acceptable vs. unacceptable ways of expressing anger. The child learns to shift to less direct expressions of anger. Rather than hitting or yelling or talking he might pout, dawdle, break a sibling's toy, hide something, or threaten not to love mommy or daddy.

By age six most children begin to answer the question, "Who am I?" Little boys begin to learn that they are to become "just like daddy" and enjoy playing this role. They give up wanting mommy all to themselves and settle for having a girl just like their mother (some day). Little girls begin to learn that they are to become "just like mommy" and enjoy playing this role. They give up wanting daddy all to themselves and look forward to some day having

someone just like their father. As I will discuss later, the role model of the parent is critical. If a parent inappropriately expresses anger the child might incorporate this model as his concept of identity.

One of the psychological processes that develops at about age six and that assists the child in handling his or her many conflicting feelings and thoughts is the consolidation of various value judgments into a conscience or super ego. This "voice" of our conscience remains with us throughout life and becomes significant. It "tells" the child what thoughts, feelings, or actions are acceptable or not. Initially, these concepts are taught by one's parents. Later, in adolescence, these value judgments are reconsidered. The early value systems are usually concrete and possibly harsh. If not reworked in adolescence, such a super ego can inhibit or confuse one's identity or one's ability to handle feelings appropriately.

Once the child masters this third task of development, individuation, he or she moves into a period of consolidation. By about age six, the child is free to move out of the family and into the community. With the major psychological work of childhood done, the child's energy is freed to involve him in school and learning and in peer relationships.

Earlier learned roles continue to be reinforced. Boys are taught to play certain games and girls others. Boys do certain activities and girls do others. Boys can dress in certain ways and girls in others. Boys can express certain feelings and girls others.

Children begin to learn of a more socially-acceptable model of expressing anger, i.e., games and sports. One can be extremely aggressive in competitive games and sports and it is acceptable and safe. There are clear rules, concepts of "sportsmanship," and referees or umpires to maintain the rules. If one is defeated he is not hurt or destroyed. One shakes hands and friendships remain. This ability to channel one's expression of anger into games and sports may continue throughout life through direct involvement in sports or hobbies, work, or

passive observation.

During this time children begin to focus on relationships with the same sex and ignore or move away from heterosexual peer activities. Boys prefer boys and may not like girls. Girls prefer girls and may avoid boys. Very intimate "chum" relationships develop. Unlike the previous stage, the boy will shrug and push mother away if she wishes to kiss him; the girl will feel uncomfortable if father chooses to hold or to kiss her. Two girls or two boys may walk down the street arm in arm as the closest of friends. The ability to relate and form friendships with persons of the same sex is explored and learned.

By the age of 12 to 14 this period of consolidation ends. Adolescence arrives. It is useful to distinguish between puberty, the physical processes of change, and adolescence, the psycho-social processes of change. Preferably, the two occur simultaneously or close to each other; however, with some individuals either may occur much before the other. When one is out of phase with the other the individual has added stresses to cope with.

The pre-adolescent stage usually begins at about the age of 11 to 13 with girls and 12 to 14 with boys. Interest in the opposite sex reappears. For many reasons the early adolescent may not return to individuals within the family to explore these new relationships and feelings but may look outside the family.

During the early phase of this developmental period, he may continue peer relationships with the same sex but the interest shifts. Groups of girls may get together to talk and giggle about boys. Groups of boys may laugh or joke about girls. Such laughter and jokes become a comfortable way of handling the anxiety created as they begin to re-explore heterosexual feelings and thoughts.

Much as the young child learns to master new tasks and problems through play and through repetition in play; so, the pre-adolescent begins to master his new feelings and thoughts through fantasy and play. While reading stories,

daydreaming, talking or making up stories with friends, they begin to explore and to role-play new behaviors and interactions before actually trying them out.

Through the safety of peer groups of the same sex, they begin actively to re-explore heterosexual interactions. Groups of girls may sit in a booth at an ice cream parlor, laughing about a group of boys across the way. Groups of boys might clown around when near a group of girls. This behavior might lead to group parties or dances and then gradually to individual heterosexual interactions.

The individual is developing bodily changes which lead to two conflicting issues and create the first developmental task to be mastered in adolescence, shifting from a dependent to an independent person.

The first result of the physical maturation is a loss of self-confidence and a loss of feelings of body mastery. These feelings may lead to withdrawal from peer contacts and retreat into the home. He is growing in height and weight. Bodily changes such as menarche, breast development, growth of beard, and changes in voice occur rapidly. The girl who may have been very graceful and reassured is now clumsy and insecure. The boy who was great in sports and confident is now gawky and uncomfortable. Every day he looks into the mirror to see who is there and to readjust.

Although the rapid physical and emotional development may increase one's insecurity and his wish to retreat into the safety of the home and family, another aspect of this development may force the individual to move out of the home for relationships and interactions.

Unlike the child of three to six, whose feelings and thoughts caused conflicts and anxiety, the adolescent has the additional capacity of actions. When a six-year-old boy cuddles in his mother's lap he feels pleasant sensations, but when the 14 or 15-year-old boy does so, he may be embarrassed by development of an erection. A little girl can enjoy the experience of cuddling with her father, but an early adolescent girl

may have concomitant physical sensations or secretions that worry her. Wrestling or tickling a sibling of the opposite sex may become equally stimulating and distressing. This new ability to add actions to the feelings and thoughts is upsetting and may force the adolescent to move such relationships and feelings to individuals outside of the family.

The same is true for angry feelings. It is one thing for a little boy to be angry at his mother as he looks up at her. It is another situation when the angry adolescent realizes that he is taller and bigger than his mother and that he really could hurt her.

Thus, there is a conflict. The loss of confidence caused by the physical and emotional changes encourages the early adolescent to become more dependent on his home and parents. The maturation of sexual functioning makes it difficult to explore heterosexual relationships again with parents and siblings.

Initially, the early adolescent may attempt to cope by fantasy, i.e., choosing relationships with individuals who are unavailable, thus safe. He might have a "mad crush" on a movie or record star or on a sports hero. The probability of an early adolescent girl suddenly having a rock music star knock at her door and ask for a date is remote enough to allow her safely to fantasize a relationship with him. Gradually, relationships with real, potentially available people are explored. Initially these interactions are likely to be found in groups, then smaller groups, and then individually. Early individual dating may be narcissistically-determined. The adolescent dates someone who makes him or her look good—the cheerleader or football hero. Often the boy relates to the girl much as he would to boys by clowning around or hitting. Later, the adolescent will date someone who makes him feel good; this date may resemble the parent of the opposite sex.

As the early adolescent struggles to move from a dependent to an independent person, the initial struggles often revolve around the established concepts of sexual roles and identification. Old techniques of mastering separa-



tion may be tried again.

Negativism reappears. "No, I can do it myself." "Don't tell me how long my hair can be." "Don't tell me how short my skirt can be." Again, the negativism is an attempt to say that he has a mind of his own. Again it can become an active verbal expression of anger.

Clothing and hair style have always been favorite issues to prove one's independence. The unisex theme of today resembles the "cause" of other generations who had "Raccoon-Coaters," "Beep-Boppers," "Zoot-Suiters," "Flappers," and so on.

Other issues relating to establishing that the adolescent has a mind separate from his or her parents may appear. Parents and adolescent may differ on the choice of friends and peer groups, on school plans or courses, on points of philosophy.

All the old struggles with loving and with angry feelings reappear. What do you have to do to be loved or to keep one's love? What do you do with angry feelings? All have to be worked through; in the process developing concepts of relationships, styles of expressing feelings, and one's personality are shaped.

In the process of separating, the adolescent must reject and reformulate his conscience or superego. Unless this is done, the adolescent's parents remain with him in the form of the value systems programed in as a child. Initially the adolescent might reject the former values, pointing out the contradictions in the parents' values or stating that "one can't trust anyone over 30." For some, this interim "vacuum," when old values are rejected but new ones have not yet been established, is upsetting. The adolescent might temporarily borrow a "packaged" system. Boy Scout or Girl Scout Oaths and Laws, religious philosophy and ritual, or other value systems might be adhered to vigorously. For some, the peer group may provide this interim system. Close "clicks" may set rigid rules about how to dress, whom to talk to, who is in the in-group or out-group, or how to behave.

Slowly, the adolescent begins to blend many different value concepts from many sources with his or her existing values. By young adulthood a new superego is established. The flexibility and compatability of this new superego will strengthen or inhibit the individual's ability to handle and express feelings and relationships.

As the adolescent begins to feel independent of his family and the family supports and encourages this emerging maturity, the question of the three to six-year-old reappears. Now that I am a separate being, "Who am I?" He can no longer be just like mommy or daddy.

Thus, the second developmental task of adolescence, establishing one's identity, begins. Becoming a "chip off the old block" is too restrictive. Unlike the child, the older adolescents will select characteristics from many individuals such as religious leaders, scout leaders, teachers, neighbors, relatives, parents, and friends and blend these features with himself to become a unique new person. This new person, or identity, finalizes one's concepts of self. An individual's identity must be reworked throughout life as life roles change. One must adjust to becoming a graduate, a spouse, a parent, a grandparent, or a retiree.

Each generation and each culture has different sociological and cultural influences. The child who grew up in the Victorian era would have had different external messages influencing his or her identity than one growing up in the first post-Victorian rebellion, i.e., the "flapper stage" of the 20's. In the same way, the adolescent growing up today experiences different social and cultural mores and standards than did his parents.

The total developmental process that began at birth culminates in this identity. If all previous tasks were successfully mastered, the individual will have a successful functional identity with healthy and positive feelings about himself or herself. If any tasks were not successfully mastered, the final identity might be restrictive or dysfunctional.

With the developmental task of moving from a dependent to an independent being and establishing his initial identity complete, the adolescent has one remaining task to master. Until this time relationships were primarily based on the child-adult model. Now, the adolescent or young adult has to learn how to relate to another individual who is an equal. This type of relationship is often referred to as intimacy.

When relating in a dependent-independent model one leans on or depends on another, and possibly may fuse with that person. In an intimate relationship or an independent-independent relationship each becomes intra-independent on the other. Although each leans on and needs the other for his emotional well-being, neither loses his boundaries; at all times each can still stand and function independently.

### The Family

All of this psychological and social development usually takes place within a family setting. This family should provide a comfortable, nurturing, safe environment. The adults should provide role models for the behaviors being taught.

The child gradually should learn to establish trust in others, master separation, learning to function independently, and conceptualize his identification. The adolescent should finalize the process or, moving from a dependent to an independent person, finalize the basic concepts of his identity and learn to relate to adults as an adult.

The child should learn that relationships are positive experiences. With those significant adults in his life, the child learns that relationships mean loving and being loved, trusting and not being hurt.

Gradually the child learns to control his aggressive feelings and thoughts by learning acceptable behaviors. The child learns to move from overt actions to selected actions to words to selected words to thoughts to selected thoughts or to alternative, acceptable behaviors.

It is in the process of learning that relationships are positive—loving and being loved—and in the process of gaining control over his impulses, thus handling angry feelings and thoughts in more socially acceptable ways, that adult role models are important. If the significant adults are unavailable, inconsistent in their relationships, or acting in a manner different from the behaviors expected from the child, the child might have difficulty. If the parents try to insist that a child not openly express anger, yet mother yells or throws things when she is angry or upset or father pounds his fist or hits mother when he is angry, the child will become confused between the verbal messages and the observed messages. If parents handle conflicts by yelling or hitting, then siblings might begin to use the same approach when they disagree or get upset. If a parent is impulsive and explosive with his angry feelings, the child sees such behavior as a possible role model to try.

In addition, if the child's family is under stress and thus unable to provide a safe, nurturing environment, the child might have difficulty progressing psychosocially and might remain at an earlier level of development and behavior.

### Child Abuse and the Mastery of Aggression

Several previous studies, including one by the author, have shown that violence within a family breeds violence.<sup>1</sup> When one parent abuses other members of the family the child's development is effected. Some children are able to develop specific intrapsychic defense mechanisms and cope. They develop into functional adults, often paying the price of a restricted or partly dysfunctional personality.

Other children might choose one of two other methods of coping. Some learn to cope with the stress by *identification with the aggressor*. They learn to handle their aggressive feelings and thoughts by modeling after the aggressive parent. They have poor impulse control in general and express their aggressive feelings and thoughts directly. Those abused children grow up to be impulsive aggressive adults and

often become child abusers.

Several case examples from the author's study of child abuse illustrate this theme.<sup>1</sup>

*Case 1*—A six-month-old girl was brought to the emergency room because her mother had knocked her unconscious. The father reported a similar previous episode, however, he had not brought the child in at that time. Information revealed that the mother had been abused by her mother as a child and had been known to the police department since her early teens because of alcoholism and disorderly conduct.

*Case 2*—A two-month-old child was brought to the emergency room by his father, who complained that the mother had beaten him. In addition to clinical evidence of soft tissue injury, the child showed evidence of neglect (diaper rash, weight loss). Records noted that the mother had been abused by her father as a child. She had been known to the police department since her early teens because of alcoholism, assaultive behavior, and disorderly conduct. On the first day following hospitalization of the child, his mother removed him without medical approval. The Women's Bureau went to the home and returned the child to the hospital. On readmission, a fractured skull, which had not been present at the time of the original admission, was noted.

*Case 3*—A six and one-half-year-old child, observed in the emergency room, was found to have multiple hematomas, welts, and contusions. History revealed that the father had beaten the child with a belt. Records showed that the father had been abused as a child; he was described as violent and abusive to his wife and to the other five siblings. Two months after the event described above, the child was seen in the emergency room with a similar beating; at this time he was noted to have torticollis. Follow-up reports note that four years after the initial event the child was enuretic and had phobias.

*Case 4*—A one-year-old child was seen in the emergency room after a neighbor's complaint led the police to the child's house. He was found alone in a dirty and disorganized house; the refrigerator was broken, and gas fumes were in the room. Clinical evidence of neglect was noted. Records showed that the mother, as a child, had a history of running away from home because of her fear of being beaten by her mother. She had been known to the police department since childhood because of truancy, petty larceny, disorderly conduct, and assaultive behavior. During the four years after the initial episode, reports revealed abusive behavior and neglect toward all five children. One sibling died 14 months after the above incident because of "diarrhea"; another sibling was burned while playing with matches two and one-half years after the initial incident.

At the time of the study, four years after the initial reporting of abusive behavior, seven of the children had already come to the attention of the court because of delinquency.

*Case 5*—A 13-year-old was initially seen after his mother had hit him with a broom, resulting in multiple contusions. The mother had been abusive to all seven of her children; she also had stabbed her husband five years previously.

By age 17 the boy was known to the juvenile court because his behavior was out of control. He ran away from home, and broke probation.

*Case 6*—The father of an 11-year-old boy threw battery acid at him, resulting in first and second degree burns on his face. One year prior to this event the child had fractured his leg when he "fell out of bed." Records noted that all six siblings had been known to have been abused. By age 15 he was known to the juvenile court because of his school difficulties, truancy, and uncontrollable behavior; he was on probation.

*Case 7*—A 15-year-old girl had been beaten by her father with a heavy cord, resulting in multiple contusions and welts. The father was an alcoholic with at least one previous admission to a mental hospital. He was abusive to all eight children. By age 17 the girl was known to the juvenile court as a delinquent and a truant.

*Case 8*—An 11-year-old boy was beaten by his father with a belt, resulting in soft tissue injury over the face and body. A similar incident had occurred eight years previously; records revealed a long history of abuse and neglect. The father was an alcoholic, and the mother was an alcoholic with a previous admission to a mental hospital. All siblings were known to have been abused at one time or another. By age 15 the boy was known to the juvenile court because of his behavior in school, delinquency, and truancy; he was also known to be enuretic.

*Case 9*—A nine-year, nine-month-old boy, had been beaten by his father with resulting soft tissue injury. The father had a previous admission to a mental hospital. By age 13, the child was known to the juvenile court because of assault with a deadly weapon, housebreaking, stealing, and breaking probation.

Some of these children appear to cope with the stress by *identification with the victim*. Rather than becoming impulsive aggressive adults they become the victim: the wife-beater's wife, the person yoked, the person attacked and beaten. At an early age children who are repeatedly battered learn to sense when it is time to go outside, to leave the room, to be quiet. Through painful experience they have learned the consequence of allowing their parent to lose control. These children, however, under similar conditions, perform just the act or say just the word that precipitates a beating or abuse. They seem to have learned that love equals being hurt and they establish a pattern of inviting harm and of playing the victim. Rather than relating in a love and be loved model they relate in a hurt and be hurt model.

Sirhan Bishana Sirhan, the convicted assassin of Robert F. Kennedy, is one example of the theme that violence breeds violence, with



undesirable consequences to society. Teachers, pastors, and boyhood acquaintances who had known Sirhan in Jerusalem reported that he grew up in violence. Salim Awad, the headmaster of the Jerusalem Evangelical Lutheran School, was quoted as saying, "What the (school) records do not show is what went on at home. The father and mother had terrible fights, and the children suffered as a result. Their father beat them. . ."<sup>1</sup>

Pastor Daoud Haddad of the Lutheran Church of the Savior in Jerusalem stated that the father "had frequent violent fits and was given to breaking what little furniture they had, and beating the children. He thrashed them with sticks and with his fists, whenever they disobeyed him."<sup>1</sup>

Salin Atas, a boyhood acquaintance of Sirhan, related an incident when the father heated an iron and pressed it against Sirhan's heel. "I remember Sirhan coming to school with no shoes."<sup>1</sup>

### Television — That Other Member of the Family

What is the effect on child development and modeling of the mass media, especially television? In most American families the television set is like another member of the family. The child might see, hear, and interact as much with the television set as he does with a family member.

In an earlier time the child was socialized by his family with strong and congruent support from community, religious institutions, and school. Today, however, the mass media plays a significant role in socialization, introducing the child to options he might not otherwise know about, and teaching the child how to value these options.

There is concern with those media which are visual—comic books, motion pictures, and television. Possibly, something portrayed has a much greater impact than something merely read about. In addition to this impact, there is the concern with its "availability." Literacy

may have provided a useful screen, since an individual had to reach a certain level of maturity and intellectual ability to be able to read. However, any child of any age or intellectual ability is able to watch and be affected by a picture.

It is estimated that the average American child between the ages of five and fifteen sees some 13,400 human beings destroyed on his television set.<sup>2</sup> In growing up, the typical child in this country spends as much time with television as he does in our education system. He spends more of his waking hours watching television than in any other single activity. Dr. Urie Bronfenbrenner, a social scientist at Cornell University, has said that, "The normal American family now consists of a father, a mother, 2.4 children, and one television set. Along with the parents, this new family member must accept his full measure of responsibility for the human, or inhuman, quality of the new generation of Americans".<sup>2</sup>

If the child sees so much violence on television, is it possible that he learns that violence pays off? Is it possible that the child has his sensitivity to violence blunted? In one study children were left to monitor the videotaped play behavior of other children.<sup>2</sup> They were instructed to go and get the experimenter if things got out of hand. In the video sequence, which the child thought was actual children in another room at the same time, things did indeed get out of hand. Progressively, more mayhem began to take place. Those children who had just seen commercial television violence accepted much higher levels of aggression than those who had not.

To understand how television might be linked to aggression one has to look at the learning model. Initially children learn models of behavior by observing it. This does not necessarily mean that the child will replicate the behavior. It is in his cognitive repertoire, but it may not be in his behavioral repertoire. Later, the child might actually adopt the modeled behavior into his pattern of actions.

Perhaps the lesson of television violence is

not just that a child sees and learns how to deliver a karate chop or write a bomb threat; it may be that he learns the broader lesson: the surest and most effective answer to a problem is violence.

## Discussion

In the process of development the child becomes socialized. He learns acceptable from non-acceptable ways of handling feelings, thoughts, and actions.

If the family environment is stressful or if a parent uses aggressive behavior, such as in child abuse, the child is likely to grow up as an immature, impulsive, aggressive adult. Violence does breed violence.

The possible influences of television on children only can be suggested at this time. The Surgeon General of the United States, after reviewing the data from a scientific advisory committee similar to the one that linked cigarette smoking to cancer, publicly concluded, "While the committee report is carefully phrased and qualified in language acceptable to social scientists, it is clear to me that the causal relationship between televised violence and antisocial behavior is sufficient to warrant appropriate and immediate action."<sup>2</sup>

A possible consequence of a child's exposure to violence within the family or by television is the producing of a violent adult. This individual affects all of society.

A recent study by the Massachusetts Institute of Technology reported some striking projections about violence in our society.<sup>3</sup> An infant born in a major city today has a two percent probability of having his or her life terminated by murder. This means that the odds against a male infant in an American city today are worse than those faced by a young man entering the armed services in World War II.

This violence within our society strikes at many levels. There is the direct injury to an individual and the secondary pain felt by the

victim's family. But, there is also the reality that we are all victims. The threat of violence subtly undermines the quality of our lives. We all feel the anxiety, the fear, and the loss of freedom to move where and when we like. We live with the anxious knowledge that we or our loved ones could be mugged, beaten, raped, stabbed, shot, murdered, bombed, skyjacked, or kidnapped. Violence has disrupted civilization as we have known it and the democratic process as it has evolved over centuries. In our time we have seen the assassination of President John F. Kennedy, Senator Robert Kennedy, Civil Rights Leader Martin Luther King, and the attempted assassination of Governor George Wallace. We have seen riots and political kidnapping. Violence at this level makes it difficult for a democratic leader to move freely among his people. It forces potential leaders to reconsider the risks they invite on themselves and their family.

Families under stress or dysfunctional families potentially raise their children to express aggression openly. Violence within families breeds violence. All of society feels this violence and is affected.

## Conclusions

For the sake of the success and happiness of the individual as well as the safety and survival of our society it is essential for the child to learn acceptable from non-acceptable models for handling aggressive feelings, thoughts, and actions.

Such learning takes place within the family. With the proper family environment the child develops into a "socialized" adult. In a dysfunctional family environment where violence is expressed the child is likely to develop into a violent adult.

We no longer can afford to allow violence to breed violence. We must intercede to break this cycle. Dysfunctional adults and families must be helped before they cycle their children into our next generation of dysfunctional adults and families. The effects of the mass media,

especially television, must be studied further. The effect of the content of television programs we pour into our children must be understood. Actions may be needed.

The happiness of the individual is at stake. The future of society is at stake. We must proceed.

*Rutgers Medical School, Piscataway*

## References

1. Silver LB, Dublin CC, Lourie RS: Does violence breed violence? Contributions from a study of the child abuse syndrome. *Amer J Psychiat* 126:404-407, September 1969.
2. Cited in: American Academy of Pediatrics. TV and children: The effects of violence. *News and Comment* 25:8-13, July 1974.

## New Treatment Prevents Serious Disease of Premature Infants

A new treatment to prevent hyaline membrane disease—a serious respiratory disorder in premature newborns—is described in the April 25 edition of *JAMA*.

A research project at Roswell Park Memorial Institute, Buffalo, New York, confirmed that administration of plasminogen, a substance extracted from human blood, within 60 minutes of birth brings a substantial decrease in severe breathing problems and in death from hyaline membrane disease in premature newborns.

The most common cause of death in both premature and full-term infants in the hours following birth is respiratory difficulty. About half such affected infants are found to have an excess of pink fluid clinging to the membranes of the bronchial tubes—the condition called hyaline membrane disease (HMD). Statistical studies have shown that HMD and respiratory distress is the underlying cause of death in some 9,000 infants each year, approximately 20 percent of all neonatal deaths.

Clara M. Ambrus, M.D., of Roswell Park Memorial Institute, and colleagues report on a study involving 500 premature infants. Half were treated within an hour of birth with plas-

minogen. Half received a placebo. The patients were in four hospitals affiliated with the State University of New York at Buffalo. In each hospital the study was approved by the Committee on Human Experimentation.

Of the 249 infants in the placebo group, 22 had mild and 31 severe respiratory distress. Of the last 31, twenty died; 11 had HMD. In the plasminogen-treated group of 251 infants, mild respiratory distress developed in 35 patients and severe respiratory distress in 19. This is the reverse of the ratio observed in the placebo group. Of the latter 19, six died.

Administration of plasminogen did not change the overall occurrence of respiratory distress in premature infants, but its use often converted a potentially serious disease into a mild one of short duration requiring minimal care, the report says. Plasminogen is given in a single intravenous injection shortly after birth. It can be administered by the family physician, obstetrician, or pediatrician, and a sophisticated intensive care unit is not required.

Mortality caused by HMD in the plasminogen group was about one-fourth that in the placebo group, Dr. Ambrus says.



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# CASE REPORTS

*Traumatic thrombosis of the internal carotid artery following blunt cervical trauma is rare. In almost all reported cases the lesion was not recognized and the patient's symptoms were thought due to intracranial injury. The trauma may be slight, and the patient may exhibit only minor abrasions in the cervical area. With cervical hyperextension injury, the neck may appear completely normal. Following a latent interval of twenty-four hours or less, the patient may develop pupil dilatation, hemiparesis, aphasia, and/or sensory deficit. In the collected cases, there has been a 40 percent mortality and 52 percent incidence of residual neurologic deficit.<sup>2</sup> Although somewhat controversial, current therapeutic approach is non-operative and directed toward restoration of collateral flow.*

## Thrombosis of the Internal Carotid Artery Following Non-Penetrating Cranio-Cervical Trauma\*

**Edwin S. Wilson, M.D., Mount Holly**

The syndrome of traumatic thrombosis of the internal carotid artery following non-penetrating injury to the head and neck is rare. Verneuil in 1872 was the first to describe thrombosis of the internal carotid artery following blunt trauma.<sup>1</sup> In that first patient, as in many subsequent patients, the symptoms were felt to reflect intracranial injury. In a review of the literature published in 1967, Yamada, *et al.* noted that only fifty-one reported cases had been substantiated by carotid angiogram, operation, or autopsy.<sup>2</sup> Scattered case reports have been published since that review, but the overall occurrence is rare despite the increasing incidence of motor vehicular accidents.

This report of a young patient who developed internal carotid artery thrombosis following seemingly minor trauma to the head and neck, illustrates the typical mode of presentation and clinical course. Diagnosis was established by the early utilization of carotid angiography.

**Case Report** — A 24-year-old male was admitted to the hospital following a motor vehicle accident. Although his head struck the steering wheel of the automobile, there was no history of direct trauma to the neck. The patient was conscious and restless, but refused to respond to questions regarding the accident or his state of health. Physical examination in the emergency department revealed multiple small lacerations of the forehead, right cheek, lower lip, and chin. There was a deep laceration of the anterior aspect of the right knee. Blood pressure was 130/70. Fundoscopic examination was normal, and the pupils were equal and reacted

normally to light. Cardiac rhythm was regular with no murmurs, but the heart rate was increased to 120 per minute. There were superficial abrasions of the abdomen and hips, but no abdominal rigidity or rebound tenderness. Neurologic examination was normal.

Radiographic examinations of the skull, chest, and right knee were normal. Hemoglobin was 15.1; the white cell count was 24,000 cells per cubic millimeter.

Twelve hours following admission to the hospital, the patient became increasingly restless and disoriented, and soon developed dilatation of the right pupil, left facial weakness, and left hemiparesis. Emergency right brachial and left carotid angiography were performed, with the tentative diagnosis of acute subdural hematoma. Left carotid angiography was completely normal. Right brachial arteriography demonstrated filling of the right vertebral artery and the posterior circulation, as well as the right external carotid artery and its branch vessels. The right common carotid bifurcation was normal, but a tapered occlusion of the right internal carotid artery was demonstrated three centimeters above the bifurcation. There was no intracranial opacification by the right carotid artery, but crossover filling of the right anterior and middle cerebral arteries occurred during left carotid angiography.

Because of the collateral filling of the right cerebral circulation and the young age of the patient, a conservative approach was elected. In the intensive care unit, therapy was instituted with systemic steroid therapy and supportive measures. Within four days the patient was more alert and responsive, but with residual right Horner's syndrome and paresis of the left upper extremity. During this period a transient pericardial friction rub was heard, and an electrocardiogram revealed incomplete right bundle branch block and slight depression of the ST segment in AVF. Radiographs of the chest and sternum were normal. The electrocardiogram reverted to normal in three days.

\*From the Department of Radiology, Burlington County Memorial Hospital, Mount Holly.





Figure 1—Lateral radiograph from the right brachial injection demonstrates occlusion of the right internal carotid artery.

Within four weeks the patient was discharged from the hospital with no residual paresis, but with slightly obtunded sensation of the left upper extremity. Neurological examination was otherwise within normal limits. The patient refused a second carotid arteriogram.

### Discussion

Thrombosis of the internal carotid artery following blunt cervical or cranial trauma is rare. In virtually all cases, the admitting diagnosis indicated that physicians considered the symptoms due to intracranial injury and the carotid occlusion was not suspected. However obscure the trauma, the entity is a serious one, as reflected by the 40 percent mortality rate and the 52 percent incidence of residual neurological deficit.<sup>2</sup>

The trauma may seem slight, and the patient may exhibit only a slight abrasion in the cervical area. In some cases there may be no visible evidence of external trauma to the neck. Intimal tear with subsequent thrombosis is the most usually accepted mechanism of injury.<sup>3,4,5</sup> This may follow direct trauma to the vessel, sudden



Figure 2—Frontal (a) and lateral (b) subtraction radiographs demonstrate complete obstruction of the right internal carotid artery distal to the bifurcation.



stretching of the vessel during hyperextension of the cervical spine, or blunt intraoral trauma.<sup>6</sup> With the marked increase in motor vehicular accidents, sudden stretching of the vessels appears the more prevalent mechanism. As the vessel is stretched across the hyperextended cervical vertebrae, there is intimal tearing, while the media and adventitia may remain intact and preserve continuity of the vessel. This partial tearing of the vessel with subsequent thrombosis provides the probable mechanism for the latent period which characterizes this injury.<sup>3</sup>

These patients usually present minimal symptoms when initially examined. However, more serious findings become manifest after a latent interval of variable duration. This period usually suggests epidural or subdural hematoma to the physician. In most patients, there is no discernible alteration in carotid pulse and no carotid bruit.<sup>2</sup> Ipsilateral Horner's syndrome is often present, due to concurrent injury to the sympathetic cervical chain. These patients may rapidly develop restlessness, confusion, and hemiparesis. Aphasia may become manifest if the dominant hemisphere is involved. A prevalent finding in those cases reported in the literature is the tendency for the patient to remain conscious despite severe neurologic deficit.<sup>4</sup>

There is a controversy regarding the correct therapeutic approach to this serious lesion. Most authors believe the correct treatment of carotid thrombosis due to blunt trauma is nonoperative, especially in the face of a dynamic neurological deficit.<sup>4,7,8,9,10</sup> The major concern is that the operative restoration of blood flow to an ischemic infarct will produce a hemorrhagic in-

farction with increased mortality.<sup>4</sup> A 40 percent mortality is recorded in the literature.<sup>2</sup> Conservative medical measures including the control of fluid balance, maintenance of respiration and blood pressure, mannitol and/or steroids to decrease cerebral edema, and mild sedation are utilized.<sup>2,4</sup> Once the neurological deficit has stabilized, repeat angiography and consideration of surgical repair to increase cerebral perfusion may be indicated in selected patients.<sup>4,8</sup>

## References

1. Verneuil M: Thrombose de l'artere carotide. *Bull Acad Nat Med* 1:46-56, 1872.
2. Yamada S, Kindt GW, and Youmans JR: Carotid artery occlusion due to non-penetrating injury. *J Trauma* 7:333-342, 1967.
3. Zilkha A: Traumatic occlusion of the internal carotid artery. *Radiology* 97:543-548, 1970.
4. Towne JB, Neis DD, and Smith JW: Thrombosis of the internal carotid artery following blunt cervical trauma. *Arch Surg* 104:565-568, 1972.
5. Olafson RA and Christoferson LA: The syndrome of carotid occlusion following minor craniocerebral trauma. *J Neurosurg* 33:636-639, 1970.
6. Pitner SE: Carotid thrombosis due to intraoral trauma. *N Engl J Med* 274:764-767, 1966.
7. Blaisdell WF, Clauss RH, Galbraith JG, Imparato AM, and Wylie EJ: Joint study of extracranial arterial occlusion. *JAMA* 209:1889-1895, 1969.
8. Thal ER, Snyder WH III, Hays RJ, and Perry MO: Management of carotid artery injuries. *Surg* 76:955-962, 1974.
9. Rubio PA, Reul GJ, Beall AC, Jordan GL, and De Bakey ME: Acute carotid artery injury: 25 years' experience. *J Trauma* 14:967-973, 1974.
10. Silvernail WI Jr, Croutcher DL, Byrd BR, and Pope DH: Carotid artery injury produced by blunt neck trauma. *Southern Med J* 68:310-313, 1975.

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*Abdominal calcification as seen on x-ray is an uncommon condition associated with only a few clinical conditions. The majority of the cases have been associated with pseudomyxoma peritonei and present as diffuse stippling throughout the abdomen. The case reported is that of a malignant peritoneal mesothelioma which presented with diffuse abdominal calcification caused by a large tumor that expanded rapidly, with a very malignant course, to fill the entire abdominal contents resulting in the death of the patient. The pathology of the tumor as presented, along with the x-rays, is believed to be the first reported case of peritoneal mesothelioma associated with diffuse tumor ossification.*

## Peritoneal Mesothelioma Associated with Diffuse Abdominal Ossification and Unusual Presentation\*

**John E. Stambaugh, Jr., M.D., Ph.D.,  
S. Burrows, M.D., J. Jacoby, M.D., and  
Howard Shivers, M.D., Camden**

Abdominal calcification as seen on x-ray is an uncommon condition associated usually with adenocarcinoma of the ovary, urachal carcinoma, adenocarcinoma of the appendix, pseudomyxoma peritonei, tuberculoepithelioma and gastric carcinoma.<sup>1,2</sup> The majority of the cases have been associated with pseudomyxoma peritonei and present as diffuse stippling throughout the abdomen. The following case report is interesting because a malignant peritoneal mesothelioma presented with diffuse abdominal calcification caused by a large tumor which filled the entire abdominal cavity. An additional feature is the unusual clinical course with rapid progression of the tumor in a period of a few weeks and marked enlargement over a period of several days. To our knowledge, no case similar to this ever has been described.

### Case Report

A 68-year-old male was admitted to Cooper Medical Center with a two-month history of increasing abdominal girth. One week prior to admission he developed shortness of breath and noted the onset of swelling of his ankles. Because of the abdominal distension and his wife's insistence, he consulted a physician for the first time.

His past medical and family history were noncontributory; there was no exposure to tobacco, alcohol, asbestos, or other toxins. Physical examination, at the time of his initial presentation, revealed a left pleural effusion with

marked abdominal distension due to a mass lesion extending from the xiphoid to the pubis. Ascites was present but confined to the left lower quadrant because of the large mass.

**X-ray Findings**—At the time of his initial presentation a preliminary scout film of the abdomen (Figure 1) demonstrated diffuse, amorphous granular calcifications which clustered in the mid, central, and right lower quadrants of the abdomen. The margins of these calcifications were ill-defined and did not conform to any abdominal structure.



Figure 1—Initial abdominal x-ray demonstrating diffuse granular calcification with heavy central calcification.

\*From the Departments of Medicine, Pathology, and Radiology, Cooper Medical Center, Camden.



An intravenous urogram (Figure 2) demonstrated both kidneys and ureters to be normal. Calcification was noted in the pelvis just above the urinary bladder. These calcifications tended to cluster and outline a rather spherical configuration raising the possibility of an urachal cyst. They did not involve retroperitoneal structures; a right anterior oblique projection of the barium enema (Figure 3) demonstrated extrinsic pressure upon the colon in the region of the distal descending colon. The colon itself was found to be intrinsically normal but the extensive nature of the calcifications was noted. An upper G.I. series suggested an abnormality in the lesser curvature of the distal antrum (although a biopsy of this area by endoscopy was negative). The appendix filled during the small bowel series and ruled out an appendiceal carcinoma; a liver scan was normal except for slight hepatomegaly with no intrahepatic masses noted.

*Course in Hospital*—Three liters of straw-colored fluid of Class I cytology were obtained by paracentesis, after which the mass increased rapidly over a four-day period to fill completely the area from which the ascites fluid had been taken. An exploratory laparotomy demonstrated a mass which extended from the xiphoid to deep into the pelvis and to both lateral abdominal walls. No ascites was present; the tumor which filled the entire left lower quadrant, was described as "rock hard" and so firm that it was difficult to biopsy. No further exploration of the abdomen was possible and the tumor could not be removed. The pathologic diagnosis was reported as a malignant mesothelioma, fibrous type, associated with a fibrinous exudate and tumor calcification. A course of chemotherapy and radiation therapy was instituted. After two weeks of treatment the patient developed right costovertebral angle tenderness and intermittent chills and fever. A repeat intravenous pyelogram demonstrated bilateral obstructive uropathy secondary to pressure by the tumor. The patient developed

signs and symptoms suggesting gram-negative septicemia and bronchopneumonia; the laboratory data demonstrated progressive deterioration of renal function and uremia. After 48 hours the patient expired; a postmortem was obtained.

## Pathology

At autopsy a massive tumor filled the entire abdominal cavity and encircled all of the viscera of the abdomen and pelvis, without direct invasion of any of the organs. The tumor grew between loops of small intestine and gave the entire abdominal cavity a bony appearance due to extensive ossification (Figure 4). The bony composition of the tumor hampered the dissection of the individual organs and use of a saw was necessary to separate the viscera. The massive tumor caused obstruction of both ureters without ureteral invasion.

Microscopically, the tumor had the appearance of a spindle-cell sarcoma or fibrosarcoma with extensive formation of bony trabeculae (Figure 5). The tumor involved the serosal surfaces of all abdominal and pelvic viscera, including the inferior surface of the diaphragm, without invasion of the parenchyma. The cause of death was a confluent bronchopneumonia involving



Figure 2—Initial normal intravenous urogram showing diffuse stippling of a large abdominal mass.



Figure 3—Initial barium enema showing extrinsic compression by tumor without colonic invasion.

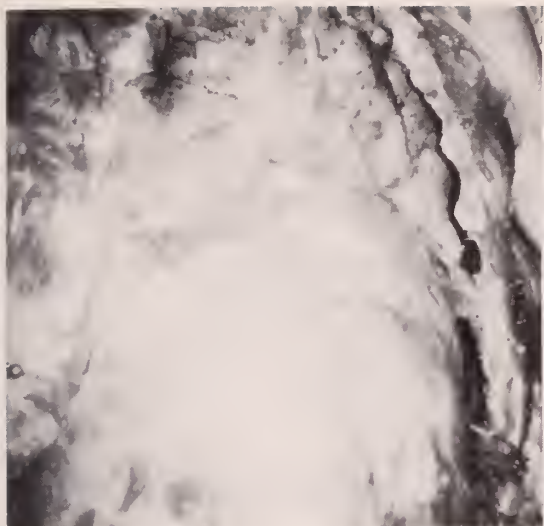


Figure 4—Gross appearance of mesothelioma showing abdominal cavity.

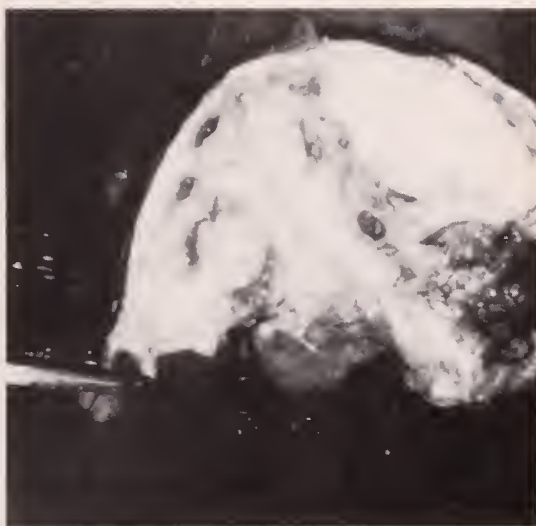


Figure 5—Cross-section of abdominal contents demonstrating complete encirclement of loops of small intestine by the calcified tumor.

both lungs and uremia due to an obstructive uropathy. No tumor was found outside of the abdominal cavity and, except for slight atherosclerosis of the aorta and coronary arteries, no other abnormalities were noted.

## Discussion

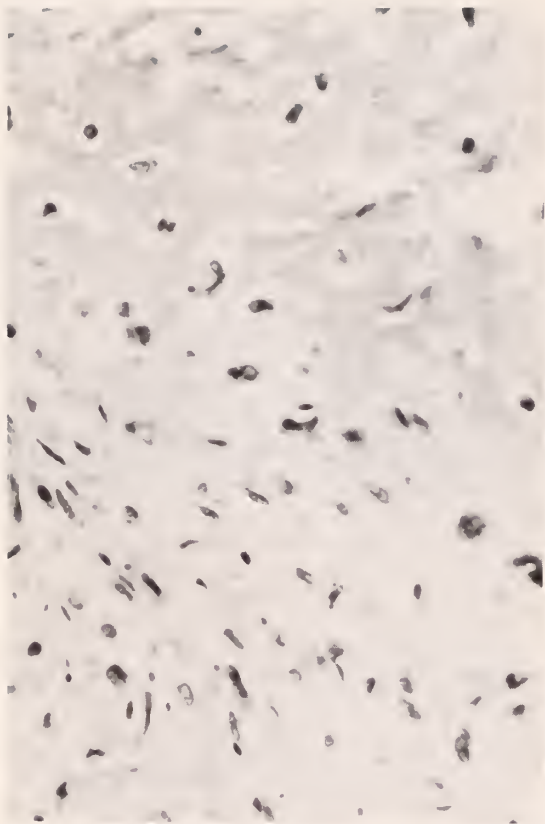
Calcification of malignant mesothelioma is an uncommon finding. Persaud *et al.*<sup>4</sup> described a case of pleural mesothelioma presenting with calcification of liver metastasis and associated with bony metastasis. Cellular morphology of their report was a spindle-cell type of mesothelioma with granular calcification of tumor. It was felt that the massive hepatic calcification was dystrophic in nature and had resulted from degenerative changes, necrosis, and repeated hemorrhage into the tumor.

The fibrosarcomatous (fibrous) or spindle-type mesothelioma is characterized as a firm, solid, grayish-pink tumor with spindle cells in arrangements of bands and whorls; it may be associated with multinucleated giant cells.<sup>1,4</sup> Although collagenization or hyalinization has been reported, the extensive calcification and the laying down of bone trabeculation as in this case has not been previously described. The calcification appears to result from an attempt of the tumor itself to form bone.



6A

Figure 6—Photomicrographs illustrating the mixture of fibrous and bony elements of the mesothelioma. Some areas had an almost equal mixture of fibrous and bony elements, as shown in C and D (original magnification of Figure 6A, X25; original magnification of 6B and 6D, X450; original magnification of Figure 6C, X100).



6B

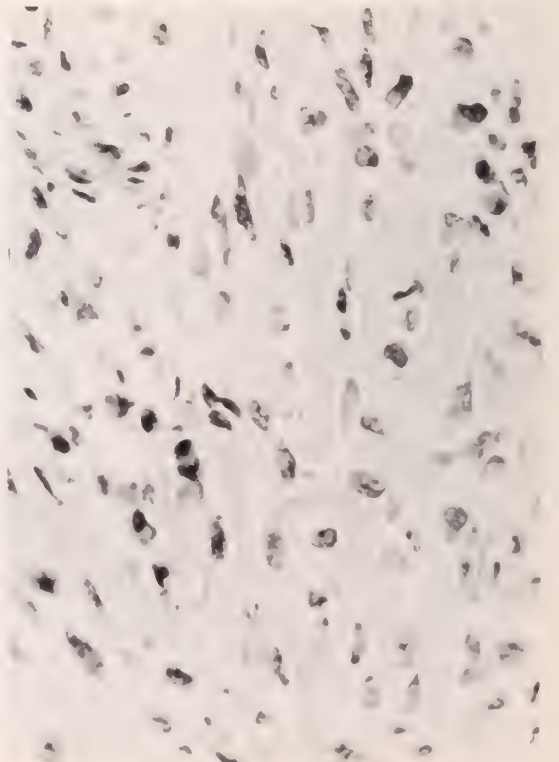


6C

Long-term survival of widespread malignant peritoneal mesothelioma has resulted only when the tumor has been completely excised. Recently the combined use of abdominal radiation and intraperitoneal injection of  $P^{32}$  has been reported.<sup>5</sup> The patient described in this report is typical of most patients with malignant mesothelioma. He presented with symptoms of increasing abdominal girth, surgical removal proved to be an impossible task at the time of laparotomy, and the tumor was unresponsive to either radiation or chemotherapy. The rapid growth of the tumor over a period of four to five days following the paracentesis indicates an unusually rapid cell division of the tumor.

### References

1. Emmett JL and Witten DM: *Clinical Urography*. Philadelphia, Saunders, 1971.
2. Fred HL, Eibano JM, Collins LC: Calcifications in intra-abdominal and retroperitoneal metastasis. *Am J Roentgen Rad Ther & Nucl Med* 9:138, 1964.
3. Holland JF and Frei E: *Cancer Medicine*. Philadelphia, Lea and Febiger, 1973.



6D



4. Persaud V, Bateson EM, Bankay CD: Pleural mesothelioma associated with massive hepatic calcification and unusual metastasis. *Cancer* 26:920-928, 1970.

5. Rogoff EE, Hilans BS, and Harvos AG: Long-term survival in patients with malignant peritoneal mesothelioma treated with irradiation. *Cancer* 32:656-664, 1973.

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## **Pediatric Briefs**

**Identification of the Jaundiced Infant Who Is Likely to Recover Without Surgical Intervention.** Campbell, D. P. and Williams, G. R.: *Am Surg* 184:189 (1976)

Lipoprotein X (LP-X) (a low density lipoprotein found only in patients with cholestasis) is always present in the serum of patients with biliary atresia. It is also found in 25% of infants with severe intrahepatic cholestasis 2° to neonatal hepatitis. Serum LP-X can be identified by a rapid simple technique. A short course of cholestyramine (CSM) may relieve intrahepatic cholestasis 2° to hepatitis by promoting bile acid excretion. Using CSM and repeating LP-X determinations before and after its use has enabled reliable differentiation between biliary atresia and neonatal hepatitis.

*Comment:* These simple procedures appear to be very reliable in determining which infants need exploration. R.H.R.

**Antidiarrheal Agents in the Treatment of Acute Diarrhea in Children.** Portnoy, B. L. *et al.*: *JAMA* 236:844 (1976)

Kaolin-pectin, kaolin, pectin, Lomotil® and placebo were compared in the treatment of nonspecific diarrhea in children age 3-11. No differences were found on any regimen compared to placebo in frequency, water content, or weight of stools.

*Comment:* This study adds to previous information showing lack of value of antibiotics in Salmonella and antiperistaltic agents in Shigellosis, and toxicity of Lomotil® in children. In the treatment of diarrhea, major attention must be paid to state of hydration. The use of "symptomatic" agents or even "specific" antibiotic therapy when subjected to careful scientific analysis becomes increasingly questionable. R.H.R.

**What Do Patients Know About Antibiotics.** Chandler, D. and Drydale, A. E.: *Lancet* 2:422 (1976)

Thirteen percent of mothers in Australia thought that antibiotics were a stronger form of aspirin. Eight percent thought aspirin an antibiotic. Seventy percent thought antibiotics should be used routinely for colds; 40% for gastroenteritis. Thirty-five percent of nurses thought antibiotics killed viruses; 45% would use them routinely for colds. "Much misinformation and confusion probably arises from doctors diagnosing 'viral infection' and then giving an antibiotic. The patient makes the obvious inference which is confirmed by improvement following (but not necessarily because of) the antibiotic. The patient then demands antibiotics for subsequent episodes; the demand is granted and the myths grow."

*Comment:* If patients are to understand the use of antibiotics, they must be prescribed rationally and with explanation of indications, actions, and side effects. We have a responsibility to educate our patients. R.H.R.

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\*Excerpts from CMDNJ Rutgers Medical School *Pediatric Newsletter* (Vol. 1, No. 2, December 1976), Richard H. Rapkin, M.D., Editor. Dr. Rapkin has given *The Journal* permission to reprint this material from time to time.

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### Does the Medical Profession Police Itself?

Recently, raucous voices purport to lend virtue to the malpractice claims which have suffused the country. That these indignant diatribes originate from persons who stand to benefit by such polemics already has been recognized. Nevertheless, their plaintive lament is that doctors do not police themselves and therefore are deserving of such severe economic sanctions which virtually threaten the practice of medicine as we know it. Such maledictions should be refuted fully because they are so manifestly unjust and dishonest.

From the moment he applies to medical school, a physician is perpetually under an intense scrutiny unparalleled in any other calling. In each competitive step of training his candidacy is judged not only on intelligence and skill, but on integrity, honesty, and ethical behavior. Each diploma, each successive license is contingent upon assurances of commendable character as well as professional attainment.

#### Peer Review

This close surveillance persists throughout the doctor's career, primarily by the observation and evaluation of his colleagues. Peer review is not an innovation, but simply an appellation for a code of critical assessment which has existed for decades. Customarily, each hospital department will survey the quality of medical attention within its own province, while tissue, audit, and other committees scour the entire panorama of professional competence in the institution. Particular consideration is paid to mortality and morbidity factors. Numerous subcommittees review infections, records, equipment, and ethical conduct. In some categories, e.g., cesarean section operations, second opinions and corroborative consultations are mandatory. Thus, the chart of virtually every patient who enters a hospital ultimately receives a thorough examination. Each year, every health facility must attest to the mental and physical capability of its entire staff.

#### Organizational Review

The county medical societies also concern themselves with technical irregularities, substandard performance, and administrative malfunction. Through their grievance committees, they are genuinely responsive to the complaints of those patients who feel themselves mistreated or in some manner abused.

Further vigilance is maintained through a series of supervisory echelons. For many years, the Joint Committee on Accreditation has studied and evaluated the character of health care provided by every facility in America and those who failed to reach prescribed standards either were placed on probation or summarily disqualified from the obvious advantages of approval. Initially, these examinations were concerned almost exclusively with case records and meeting format, but more recently, at the instigation and prodding of the AMA, they also have investigated structural hazards, modernity of equipment, and administrative responsibilities.

In addition, a cluster of other regulatory agencies have become involved and indulge in a profusion of overlapping surveys:

1. The State Department of Health is concerned with the observance of institutional criteria.
2. PSRO, with its burgeoning bureaucracy, essentially is occupied with economic aspects of hospitalization.
3. Medicare and Medicaid organizations, as governmental distributors of health funds, concern themselves with institutional and provider services.
4. Insurance providers, such as the various Blue Cross plans, are third-party payers of health care, and have concerns similar to Medicare and Medicaid.

This repetition of review and re-review, of audit and reaudit, with each agency striving to enforce its personal dominance, has, in some



instances, almost reached limits of the absurd. Such discriminatory surveillance has assailed no other profession. Furthermore, to a considerable degree, these bodies are influential in the regulation of fees.

### Continuing Medical Education

We all know that the creative vistas of medicine constantly and inexorably are expanding. Every doctor is inculcated with the dictum that learning never ceases and postgraduate education is an unending process. The hospital privileges permitted a practitioner, as well as any claim to specialty rating, depend on concrete evidence of residency or other training, specialty board certification, or officially recognized experience.

Continuing education programs have been instituted in every hospital in this state. An abundance of special courses is provided by the Academy of Medicine, the medical colleges and specialty societies. As never before in medical history, the rapid advances in scientific and technical investigation are made easily and palatably available to every physician by home courses, with tape, radio, and television learning modalities. Among the professional disciplines, the Medical Society of New Jersey makes the continuance of active practice contingent upon a minimum of 150 hours of acceptable advanced study each three years—a contingency happily adopted by our group.

### Vigilance in the Medical Profession

It has been alleged that the low number of license revocations is attributable to poor "police work." The allegation is manifestly untrue since recent statistics reveal that, over the past three years, 65 physicians have been denied the right to continue their practices in this state. It must indeed be the very rare doctor who would jeopardize his career and ultimately

destroy himself by a deliberate misdeed. Most actual malpractice involves inadvertent lapses resultant in negligence, instances of dubious judgment, surgical misadventures, or incomprehensible accidents. Although suffering, disability, and injury are possible consequences, there is generally no moral dereliction or disobedience of law.

Not every lawyer who loses a case is disbarred. Disbarment judiciously is based on premeditated, deliberate mismanagement, illegal obtainment of entrusted funds, or such unacceptable immoral characteristics as to impugn the entire bar. Inadequate professional performances rarely are accorded such extreme punishment. In a similar manner, only heinous, and gross incompetence; repetitive, irremediable malpractice habits; or incontrovertible evidence of moral deficiency merit the loss of medical licensure.

This is not to say that legitimate, punishable malpractice situations do not arise; their occurrence, however, is not attributable to the failure of police action. The implication that only the unsupervised, and the inept are the objects of suits is a malevolent canard. Experience has shown that some of the most distinguished physicians and surgeons, who perform the most complex and rewarding services, are susceptible to claims of malpractice.

Since the ancient time of Hammurabi and the first judicial code, the legal perplexities of malpractice have confounded juridical experts. To the extent that surveillance of all who are entrusted with the laying on of hands is an effective deterrent to wrongdoing, never before in the long history of the medical arts has such complete and encompassing scrutiny been performed as is presently accomplished.

Bernard D. Pinck, M.D.

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### Whole Body Extract Versus Venom Treatment in Anaphylactic Reactions to Bee Stings: The Doctor's Dilemma

An article on the diagnosis and treatment of anaphylactic reactions to hymenoptera stings appeared in the July, 1975 issue of *The Journal*, MSNJ (72:581-585).<sup>1</sup> In that article, the standard treatment using whole body extract (WBE) was discussed. It also was noted that reports were beginning to appear suggesting that pure venom (PV) was probably superior for treatment and diagnosis.<sup>2</sup>

Since the hymenoptera inject venom into their victims, it would seem logical and immunologically correct to use pure venom and not whole body extract for diagnosis and treatment. However, the retrospective clinical studies of the Insect Committee of the American Academy of Allergy, using WBE in the treatment of patients seemed reassuring.<sup>3</sup> These studies showed lesser reactions in over 90 percent of the patients treated by this method who were restung. WBE is a crude preparation containing much extraneous material such as body protein, and often little of the venom. Using WBE as a diagnostic tool often is inadequate in distinguishing the patient from the control. The final treatment maintenance dose often is not much larger than the dose where skin reactivity was first noted. Finally, we all worried about our failures and our inability accurately to advise the patients when to stop treatment.

In 1975, no prospective immunological study of WBE extracts or PV had been done on large enough numbers of patients to be of any significance. Using advanced immunological techniques over the last several years, however, two centers have published studies indicating that pure venom is superior to whole body extract for diagnosis and treatment.<sup>4,5</sup> A summary of the work from these two groups is that immediate reactions to hymenoptera stings involve IgE specific antibody to components present in PV but not present in significant quantities in WBE. A series of injections with PV produced blocking antibodies of the IgG class which appeared clinically to protect patients when next challenged in a test situation

by having the offending hymenoptera sting the patient. On the other hand, WBE showed little protection both clinically and as evidenced by lack of elevation of blocking antibody of the IgG class.

But knowing this does not solve the problem of the clinician. PV is difficult to obtain in quantities adequate for commercial distribution. So far, the only PV on the market is honeybee venom, which is available in small quantities and can be used only for diagnosis, not for treatment. The problem of obtaining large amounts of venom has not been solved nor has Federal Drug Administration approval been forthcoming. Furthermore, it does not look as though this situation will change in the near future.

Where does this leave the clinician? Should he abandon WBE without having a reliable alternative presently available? Certainly, the retrospective statistics of the Academy of Allergy Insect Committee on a large sample using WBE is impressive and all allergists have personal experience with patients successfully protected from stings using this mode of therapy. On the other hand, some of this success may be an illusion since we know that there is a natural decrease in IgE to hymenoptera with time. Also cross-reactivity between different hymenoptera is only partial and the second stinging insect may be of a different variety than the one that originally sensitized the patient.

PV seems, by modern immunological tests, to be superior to WBE but, since it is not available, it is not a viable alternative at this time.

This is the dilemma of the practitioner. If he abandons WBE he has nothing to offer the patient except avoidance and advice on how to use emergency insect kits. If he continues the use of WBE, he must recognize the shortcomings and still instruct the patients on avoidance and the use of emergency insect kits.

These are the facts; the practitioner must know them, evaluate them and decide for himself what course to follow. But the patient also must be apprised fully of the facts and allowed to participate in the decision as to which course of therapy will be taken.

Michael S. Mattikow, M.D.  
Arthur A. Goldfarb, M.D.

## Bibliography

1. Diamond M, Mattikow M and Goldfarb A: Allergic reactions to stinging insects: A review. *J Med Soc NJ* 72:581, 1975.

2. Lichtenstein LM: Anaphylactic reactions to insect stings: A new approach. *Hospital Practice* 10:67, 1975.

3. Barnard JH: Present status of therapy in hymenoptera sting sensitivity. *Ann Allergy* 29:372, 1971.

4. Sobatka AK, Valentine MD, Hart KJ, and Lichtenstein LM: Immunologic evaluation of insect allergy. Abstract of presentation before the American Academy of Allergy, March 1977, New York.

5. Reisman RE, Light WK, and Arbesman CE: Clinical application of measurements of serum bee venom specific IgE and IgG. Abstract of presentation before the American Academy of Allergy, March 1977, New York.

## INFORMATION FOR READERS AND CONTRIBUTORS

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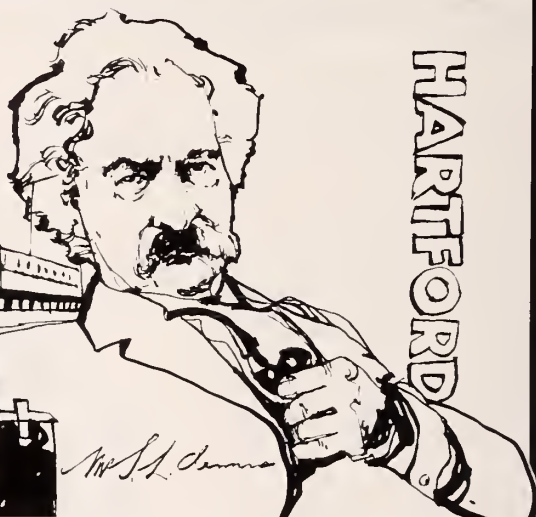
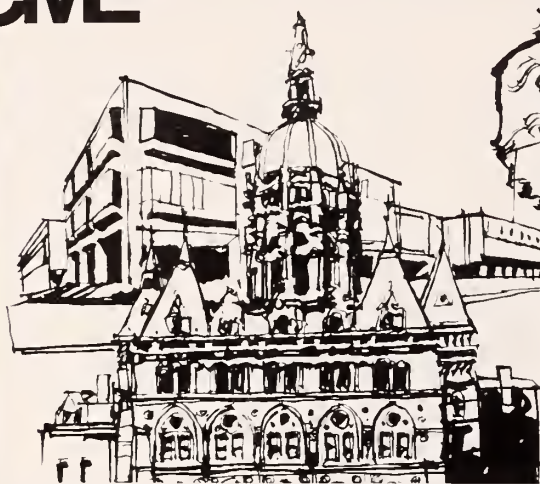


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# NEW JERSEY DOCTORS' NOTEBOOK

## CMDNJ Notes

**Stanley S. Bergen, Jr., M.D.**  
**President, CMDNJ**

At the risk of redundancy (you probably have read about this in the press) we call to your attention a proposal that will have major impact on medical education in New Jersey. The proposal calls for a \$120-million State general-obligation bond issue which must be approved in an election-day referendum before it can be implemented. Assuming voter endorsement, the State will be able to sell bonds for several College-related purposes:

1. Refinancing—at much lower cost—the two-year-old, \$109-million revenue bond issue of the New Jersey Health Care Facilities Financing Authority, which provided the money to build CMDNJ's teaching hospital in Newark. The hospital, of course, is still under construction.
2. Construction of an educational facility for CMDNJ-Rutgers Medical School at Middlesex General Hospital, New Brunswick. This is a key element in that school's expansion program. (Cost, \$12-million.)
3. The addition of two major units to the new Newark hospital: a 34-bed acute psychiatric care section and an area to house a linear accelerator and advanced radiological equipment for treating cancer. (Cost of both, \$5-million.)
4. Construction of an ambulatory care center to serve the people of Camden to provide educational experience for students in the College's projected allopathic and osteopathic programs in South Jersey. (Cost, less than \$8-million.)

The proposal (officially, A3352, the New Jersey Medical Education Facilities Bond Act of 1977) was made originally by Governor Byrne. Senator Bateman also has endorsed the plan. A spokesman for the Senator said the issue had been reviewed and felt to be "a sound mechanism for efficient use of State resources and for completing needed educational and health-care facilities."

A major reason for this bi-partisan support is that it is estimated that redemption of the NJHCFFA bonds will require only \$95 million of general obligation bonds and will save \$56 million over the life of the revenue issue, mainly

because of lower interest rates now available for general obligation bonds. The NJHCFFA bonds were sold at an average rate of 8.37 percent; the proposed issue is projected at 5 percent interest. The savings will more than pay for the contemplated new programs. In a statement last May Governor Byrne said:

"Thanks to New Jersey's strong credit position, we now can refinance the Newark teaching hospital project and apply the considerable savings to the construction of other vital medical school facilities, and still save money. These new facilities will be virtually free."

The proposal also has been endorsed by the New Jersey Commission on Capital Budgeting and Planning as "an orderly and systematic way" of meeting "critical" capital needs.

Approval by the voters does not, of course, mean automatic sale of the entire \$120 million bond issue. Each instance will require substantiation, appropriate certificates of need, and exploration of other sources of funding. Indeed, the \$25 million of new capital projects referenced in the legislation will require specific and separate approval from the legislature, as each project comes before it in the appropriations process.

When the Newark teaching hospital was planned, the psychiatric care unit and the radiological area were slated for other hospitals in accordance with a program for regionalization of health services. Because these hospitals are not able to provide those services, which are sorely needed not only for the teaching program but also for the care of residents of Newark and northern New Jersey, the CMDNJ hospital must be modified to accommodate them.

In New Brunswick, CMDNJ is negotiating an affiliation contract with Middlesex General Hospital that will enable CMDNJ-Rutgers Medical School in Piscataway to utilize MGH as its primary teaching facility. However, the proposed educational facility will have to be built to house the school's clinical teaching

components. The hospital itself will finance certain renovations and additions to its own facilities. Compared to building our own hospital, this plan will save the State in excess of \$35 million, and utilization of existing hospital facilities will help to insure continued accreditation and expansion of our CMDNJ-Rutgers Medical School.

The proposed ambulatory care center in Camden is needed not only for teaching purposes in connection with the College's long-sought osteopathic and allopathic programs in South Jersey, but also to assure access to continuity of ambulatory care for the people of that area.

## Therapeutic Drug Information Center\*

### 1. Please provide me with information concerning prazepam.

Prazepam (Verstran®) is a benzodiazepine derivative pharmacologically and chemically similar to other members of this class such as chlordiazepoxide (Librium®), diazepam (Valium®), etc. It is used as an anxiolytic agent and also has muscle relaxant and anticonvulsant activity. The drug is available in Europe and is expected to be marketed by Warner-Chilcott in the United States in the near future as its NDA has been approved.<sup>1</sup>

Although preliminary studies with prazepam utilizing dosages from 30 mg to 90 mg per day showed good anti-

anxiety activity in ambulatory patients,<sup>2,3</sup> few studies are available comparing the anti-anxiety effects of prazepam with other anti-anxiety agents. Kingston *et al.*<sup>4</sup> conducted a double-blind evaluation of prazepam, chlordiazepoxide, and placebo in non-psychotic patients with anxiety and tension. The results did not show any superiority of prazepam over chlordiazepoxide or placebo.

Silver and associates<sup>5</sup> conducted a four weeks, double-blind, placebo-controlled study comparing prazepam and chlordiazepoxide in thirty psychoneurotic outpatients. The dosage of both drugs ranged from 30 mg to 60 mg per day given in three divided doses. The results indicated that, in overall effectiveness, the patients who received chlordiazepoxide showed improvement after two weeks, while overall improvements in the prazepam group occurred after four weeks. Impotence was reported in two male patients treated with prazepam.

In conclusion, it appears prazepam is effective for the relief of anxiety and tension. It is not known if it offers any advantages over presently available anxiolytic agents.

### References

<sup>1</sup>Anon: FDA Report of NDA Approvals. *FDC Reports* T&G-6 (Jan 24) 1977.

<sup>2</sup>Dunlop E and Weisberg J: Use of prazepam for treatment of patients with anxiety: A pilot study. *J Psychopharm* 1:75-78 1966.

<sup>3</sup>Kingstone K, *et al*: Prazepam in the treatment of anxiety and tension: A clinical study of a new benzodiazepine derivative. *Curr Therap Res* 8:159-163 (Apr) 1966.

<sup>4</sup>Kingstone E, *et al*: Double-blind evaluation of prazepam chlordiazepoxide and placebo in non-psychotic patients with anxiety and tension: Some methodological considerations. *Curr Therap Res* 14:106-113 (Mar) 1969.

<sup>5</sup>Silver D, *et al*: Prazepam in the treatment of psychoneurotic outpatients: A brief report. *Curr Therap Res* 11:596-598 (Oct) 1969.

### 2. Can methyldopa be utilized effectively in a once-per-day dosage regimen?

The usual daily dosage of methyldopa (Aldomet®) is 500 mg to 2.0 gm in two to four doses.<sup>1</sup> Since a frequent dose regimen is known to foster poor patient compliance, the effect of a single daily dose of this drug has been investigated.

Wright, *et al.*<sup>2</sup> reported a controlled double-blind study comparing the efficacy of methyldopa administered in a single dose and divided doses. The study was conducted on 14 patients previously well controlled on methyldopa. Each patient received a daily dose of 0.375 g, 0.75 g, or 1.5 g of the drug (depending on the dose the patient was taking before inclusion in this study) for 12 weeks administered in divided doses three times a day. This was followed by another 12-week period in which the total daily dose of methyldopa was administered as a single bedtime dose. The antihypertensive efficacy and side effects were similar suggesting that patients receiving methyldopa in divided doses can be switched safely to a schedule in which the total daily dose is given at bedtime.

\*The Schwartz Inter-National Pharmaceutic and Therapeutic Drug Information Center of the Brooklyn College of Pharmacy, Long Island University, compiles the information contained in this column each month. The Center serves as a source of intelligence on therapeutic and pharmaceutical information not readily available to physicians, at no charge to them, and provides this information with minimal time involvement. It is staffed by trained pharmacists; Jack M. Rosenberg, Pharm. D., Associate Professor and Chairman, Division of Clinical Pharmacy, Brooklyn College of Pharmacy, is Director and Walter Modell, M.D., Emeritus Professor of Pharmacology at Cornell University Medical College, is pharmacologist consultant. The service is available Monday through Friday from 9 a.m. to 4:30 p.m.—telephone (212) 622-8989 or 303-2735. The following are questions and answers handled by the Center recently.

This month's column was prepared by J. M. Rosenberg, M.S., Pharm. D., T. M. John, B.S., M. K. Raina, M. Pharm., Ph.D., P. Sangkachand, B.S., Brooklyn College of Pharmacy, LIC



Jain, *et al.*<sup>3</sup> studied the peak and duration of blood pressure-lowering activity of a single 0.5 g morning dose of methyldopa in six female hypertensive patients who had their blood pressure stabilized. The drug was administered orally for five days and the blood pressure measured frequently. In spite of the short chemical half-life of methyldopa, there was a progressive reduction in blood pressure and evidence of cumulation and carry-over effect from one day to the next.

Dollery and Harrington,<sup>4</sup> while studying the effectiveness of methyldopa in a group of 59 hypertensive patients, administered 2-4 g of methyldopa orally in single doses to four patients. The results in these four patients showed that hypertensive action began 4 to 5 hours after administration and a significant effect on blood pressure was still noticeable 24 hours later.

In conclusion, it appears that patients maintained on divided daily doses of methyldopa also may be maintained on a dosage regimen where the entire daily dose is administered once per day. However, further long-term studies are required to see if the single dose regimen will provide effective control on the long-term basis.

#### References

- <sup>1</sup> Anon.: *Physician's Desk Reference*. Oradell, NJ, Medical Economics Company, 1977, p. 1059.
- <sup>2</sup> Wright J M, *et al*: Antihypertensive efficacy of a single bedtime dose of methyldopa. *Clin Pharm Thera* 20:733-737 (Dec) 1976.
- <sup>3</sup> Jain A K, *et al*: The effect of single doses of alpha methyldopa (MD) on blood pressure. *Clin Pharm Thera* (Abst) 14:137-138 (Jul) 1973.
- <sup>4</sup> Dollery C T and Harrington M: Methyldopa in hypertension clinical and pharmacological studies. *Lancet* 1:759-768 (Apr) 1962.

#### 3. Please provide information concerning the use of Pepto-Bismol to treat travelers' diarrhea.

Travelers to foreign countries, particularly Mexico, usually carry a supply of medicines and "don't drink the water" advice to guard against travelers' diarrhea, also known as

"Montezuma's revenge." Among the medications, streptomycin-sulfonamide combinations and kaolin mixtures are generally utilized, though prophylactic measures involving cautions with food and drink remain the keystone of prevention of the condition. There is no substantial evidence associating this disease with heat-labile toxigenic strains of *E. coli*. In one study on visitors to Mexico with travelers' diarrhea, it was shown that the most common cause was enterotoxigenic *E. coli*. Most of the strains of this *E. coli* showed susceptibility to common antimicrobial agents *in vitro*.<sup>1</sup>

Recently an over-the-counter antidiarrheal preparation Pepto-Bismol, a suspension of bismuth subsalicylate in a special vehicle, has been found to be effective in controlling diarrhea caused by heat-labile toxigenic strains of *E. coli*.

A field trial was conducted in Mexico involving 29 U.S. students who had clinical symptoms of acute diarrhea induced by toxigenic *E. coli*.<sup>2</sup> Sixteen patients were treated with Pepto-Bismol suspension, one ounce every half hour for four hours, and others were given placebos. There was no difference in the number of stools over the first few hours in either group. But significant reduction in the number of stools was observed from the fourth through the 24th hour, and the difference persisted through the 48th hour. Subjectively Pepto-Bismol reduced the incidence of diarrhea, nausea and cramps as compared to the placebo-treated group. However, there was a time lag before the drug took effect. One explanation for this lag is that the toxin that already acted on the intestinal mucosa runs its course in spite of the Pepto-Bismol. Then the drug acts on the toxin subsequently produced and reduces the number of stools. Paradoxically neither bismuth subsalicylate nor the vehicle when administered separately possessed the same effectiveness as the Pepto-Bismol suspension. It has been postulated that the manufacturer's process accounts for the effectiveness of the product.

In conclusion, Pepto-Bismol appears to be a useful drug to treat travelers' diarrhea.

#### References

1. Merson M H: Travelers' diarrhea in Mexico, *N Engl J Med* 294: 1299-1305 (Jun) 1976.
2. Anon.: Pepto-Bismol shows promise in *E. coli* turista. *Curr Presc* 102 (Jan) 1977.

## 212th Annual Meeting May 6-9

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## Report from the Foundation

Daniel J. O'Regan, M.D., Medical Director

Prepaid health care plans developing in New Jersey include:

1. Co-Med, Morris County
2. Group Health Plan of New Jersey, Hudson County
3. Crossroads Health Plan, Essex County
4. Essex County Health Organization (to affiliate with Crossroads)
5. Central Essex Health Plan
6. Newark Comprehensive Health Services Plan
7. Rutgers Community Health Plan, Middlesex County
8. Mercer Regional Health Care Plan, Trenton
9. Vineland Family Health Plan, Cumberland County
10. Health Care Plan of New Jersey, Burlington County
11. Southshore Health Plan, Atlantic County

Interested groups in other parts of the State also are looking at this concept. There is a trend toward development of ambulatory care centers in various parts of the State. This trend is part of the concept of "alternatives" to the use of the acute-care hospital bed for delivery of appropriate medical services. The New Jersey Foundation for Health Care Evaluation is interested in the Individual Practice Association (IPA) approach to prepaid care. Peer review and quality assurance will be as crucial in ambulatory settings as in the institutional sphere. With this in mind, a committee of NJFHCE is at work on the preparation of screening criteria for review of ambulatory medical services. As in the case of our originally set criteria (published in 1974) members of the specialty societies will be asked to help us. As always, we feel that the opinions of those who are in practice in the various disciplines in New Jersey will be most useful to us. Your cooperation in this effort will be appreciated.

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## PHYSICIANS SEEKING LOCATION IN NEW JERSEY

*The following physicians have written to the Executive Office of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.*

**ANESTHESIOLOGY**—Ragaie Z. Kolta, M.D., 12700 Fairhill Road, Cleveland, Ohio 44120. Ein-Shams (Cairo, Egypt) 1960. Board eligible. Group, partnership. Available.

Rodolfo Villarin Babiera, M.D., 150-72 Village Road, Apt. 104-GA, Jamaica, New York 11432. Cebu (Philippines) 1967. Board eligible. Group. Available.

Takao Uchida, M.D., 1545 NW 8th Avenue, Apt. #108, Miami, Florida 33136. Gifu (Japan) 1973. Board eligible. Solo, single specialty group, partnership. Available.

**FAMILY PRACTICE**—Bruce E. Yeamans, M.D., 5025 A Street, Omaha, Nebraska 68106. Creighton 1974. Board eligible. Small group or partnership. Available.

Jin Baik Chung, M.D., 823 Harned Street, Apt. 2-A, Perth Amboy 08861. Catholic Medical College (Korea) 1968. Solo, partnership, group, emergency room. Available July 1978.

**GENERAL PRACTICE**—Syed A. A. Shah, M.D., Mailbox No. 8, Bergen Pines County Hospital, Paramus 07652. King Edward College (Pakistan). Any type of practice. Available.

Marianne E. Carter, M.D., 45-41 39th Place, Apt. 2-D, Long Island City, New York 11104. Buenos Aires 1960. Special interest in pathology. Any type of practice. Available.

George A. Murr, III, M.D., 1611 South Broad Street, Philadelphia, Pennsylvania 19148. Hahnemann 1976. Subspecialty, emergency medicine. Group or emergency room. Available.

Terence T. Hart, M.D., 1474 Seymour Street, Apt. 5, Halifax, Nova Scotia, Canada. Subspecialty, emergency medicine. Partnership, group, or emergency room. Available.

Abdul Waheed, M.D., 5914 Shoshone Avenue, Encino, California 91316. Khyber Medical College (Pakistan) Partnership or group. Available.

Dan J. Hanco, M.D., 10 Muirhead Road, Apt. 1701, Willowdale M2J 4P9, Ontario, Canada. University of Toronto 1976. Partnership, school health, emergency room. Available.

**INTERNAL MEDICINE**—Nairvittil Chandrasikharan, M.D., Bergen Pines County Hospital, East Ridgewood

Avenue, Paramus 07652. Trivandrum (India) 1962. Subspecialty, cardiology. Board certified, (IM). Any type practice. Available.

Edward R. Deverson, M.D., 605-S Spinnaker Apts., Sea Isle City 08243. Pittsburgh, 1941. Subspecialty, geriatrics. Institutional, group, or administrative. Available.

Philip Chathampadathil, M.D., 1925 Eastchester Road, Apt. 16-D, Bronx, New York 10461. Trivandrum (India) 1968. Subspecialty, hematology/oncology. Board eligible. Hospital-based solo, group, teaching. Available.

Robin O. Motz, M.D., 1297 Dickerson Road, Teaneck 07666. Columbia University 1975. Single or multi-specialty group, research. Available July 1978.

Jeffrey M. Shapiro, M.D., 2991 School House Lane, Apt. #534E, Philadelphia, Pennsylvania 19144. University of Buenos Aires 1963. Subspecialty, gastroenterology. Board certified (IM). Solo, partnership, group. Available July 1978.

Myron A. Shoham, M.D., M.O.Q. 3011, Camp Lejeune, North Carolina 28542. Boston 1971. Subspecialty, gastroenterology. Board certified (IM). Group or partnership. Available July 1978.

**NEUROLOGY**—Hasit R. Thakore, M.D., 100 East 92nd Street, Apt. 5-A, Brooklyn, New York 11212. Municipal Medical School (India) 1968. Board eligible. Group, hospital-based, partnership. Available.

Sadasivam Modali, M.D., 51-55 Van Kleeck Street, Apt. 3-J, Elmhurst, New York 11373. Kurnool Medical College (India) 1964. Board eligible. Group, partnership, or hospital practice. Available.

**OBSTETRICS/GYNECOLOGY**—R. George Cherian, M.D., 3450-21N Wayne Avenue, Bronx, New York 10467. Kasturba (India) 1970. Board eligible. Solo or partnership. Available.

Louis J. Freedman, M.D., 210 Locust Street, Apt. 12-A, Philadelphia, Pennsylvania 19106. University of Pennsylvania. Group (specialty) or partnership. Available July 1978.

Akbar Omar, M.D., 85 Riverdale Avenue, Apt. A-642, Yonkers, New York 10701. Dow, Karachi (Pakistan). Solo, partnership, or group. Available July 1978.

Leonard Pass, M.D., 6 Douglas Mowbray Road, Peekskill, New York 10566. Board certified. Solo, partnership, or group. Available September 1977.

**OPHTHALMOLOGY**—Frederick C. Blades, M.D., 499 River Road, Fair Haven 07701. George Washington University 1969. Board eligible. Part-time, close to Red Bank. Available.

Davinder Singh Rehsia, M.D., 504-671 William Avenue, Winnipeg R3E 0Z2, Manitoba, Canada. Amritsar, Punjab (India) 1969. Board eligible. Group, partnership, or emergency room. Available. December 1977.

Howard Jay Gross, M.D., 3115 Breton Avenue, Davis, California 95616. George Washington University 1971. Solo, partnership, group. Available April 1978.

**ORTHOPEDIC SURGERY**—Michael Hahn, M.D., 85 Schuyler Drive, Edison 08817. NYU (Downstate) 1969. Board Eligible. Group or partnership. Available.

**PATHOLOGY**—Vasundhara G. Bindiganavile, M.D., 42 Walnut Street, Montclair 07042. Bangalore Medical College (India) 1969. Group or institutionally-based. Available July 1978.

Surabhan Ratanasen, M.D., 156 Corliss Avenue, Apt. 706, Johnson City, New York 13790. Chulalongkorn, Bangkok (Thailand) 1971. Board eligible. Solo, partnership, or group. Available October 1977.

**PEDIATRICS**—Harish B. Kothari, M.D., 28-03 Newtown Avenue, Long Island City, New York 11102. B. J. Medical College (India) 1969. Board eligible. Group, partnership, clinic, emergency room. Available.

Gupta B. Kuna, M.D., 200 Carman Avenue, Apt. 8-G, East Meadow, New York 11554. S.V. Medical College (Tirupah, India) 1966. Special interest—pediatric endocrinology. Board eligible. Solo practice—general pediatrics. Available.

Richard E. Manners, M.D., 11801 Monroe Street, N.E., Blaine, Minnesota 55434. Einstein 1975. Board eligible. University affiliated or group practice. Available July 1978.

Fazal Ahmad, M.D., 100 College Avenue, Apt. 6-S, North Tarrytown, New York 10591. Karachi (Pakistan) 1969. Board eligible. Any type of practice. Available.

Allen S. Retirado, M.D., 639 Albany Avenue, Apt. 4-J, Brooklyn, New York 11203. U.E. College of Medicine (Philippines) 1971. Board eligible. Group, partnership, hospital or institutionally based. Available.

Johannes B. Lukito, M.D., 2101 Canarsie Road, Brooklyn, New York 11236. University of Indonesia 1969. Board eligible. Subspecialty, hematology. Solo, partnership, or group. Available January 1978.

**RADIOLOGY**—Sun Hyung Park, M.D., 230 Elruth Court, Apt. 86, Girard, Ohio 44420. Yonsei University (Korea) 1972. Board eligible. Solo, partnership, group, institutional. Available November 1977.

**SURGERY**—Mariano S. Morales, M.D., 11 Bernard Street, Port Washington, New York 11050. Philippines 1962. Any type practice. Available.

M. Mirza, M.D., 3511 Mary Street, Endwell, New York 13760. Dow Medical College (Pakistan) 1967. Special interest, general and vascular surgery. Group, partnership, solo. Available.

Mohammad Afzal Arain, M.D., 1925 Pacific Avenue, Atlantic City 08401. Liaquat (Pakistan) 1969. Board eligible. Group, partnership, hospital-based, salaried. Available.



Por-Ming Luo, M.D., 10428 South Mason Avenue, Apt. 2-S, Oak Lawn, Illinois 60453. Taipei (Taiwan) 1967. Board eligible. Solo, group, partnership. Available.

George E. Wilkinson, Jr., M.D., 98 Marchmont Crescent, Edinburgh EH9 1HD, Scotland. CMDNJ 1972. Board eligible. Group. Available.

Jorge Antonio Melendez, M.D., 1 Hillside Drive, Batavia, New York 14020. San Agostin University (Peru) 1967. Board certified. Partnership, group, institutionally based. Available August 1978.

Sham Yung, M.D., 1035 Beach Road, Apt. B-10, Cheektowaga, New York 14225. Chung Shan Medical College (Taiwan) 1972. Board eligible. Solo, partnership, group, emergency room. Available December 1977.

Irvathur Narasimha Nayak, M.D., 115 Old Short Hills Road, Apt. 526, West Orange 07052. Stanley Medical College, Madras (India) 1963. Board eligible. Solo, partnership, group. Available January 1978.

James Fredrick Davison, 3699 Kendall Avenue, Cincinnati, Ohio 45208. St. Louis University 1972. Special interest, urological surgery. Partnership or group. Available July 1978.

Richard J. Winkle, M.D., 114 Country Club Road, Willingboro 08046. Cornell 1960. Board certified. Sub-specialty, thoracic and vascular surgery. Available.

UROLOGY—Sharat C. Kalvakota, M.D., 50 Yonkers Terrace, Yonkers, New York 10704. Gandhi Medical College (India) 1968. Group, solo, or full-time hospital-based. Available July 1978.

P. Satpathy, M.D., 6517 Landover Road, Apt. 102, Cheverly, Maryland 20785. Utkal (India) 1965. Board eligible. Any type of practice. Available.

Bruce Devon, M.D., 675 Delaware Avenue, Buffalo, New York 14202. Tufts 1973. Board eligible. Solo, partnership, or group. Available July 1978.

## LETTER TO THE JOURNAL

### In Appreciation

May 9, 1977

Dear Dr. Krosnick:

Thank you for your excellent editorial, "Hospital Rate Setting," in the May issue of *The Journal of the Medical Society of New Jersey* (74:413-414, 1977)

It really summarizes perfectly the financial situation of the urban hospitals, and more importantly, the pathetic situation of the medically indigent patient.

We have taken the liberty of distributing copies of the editorial to a number of concerned persons at this and other urban hospitals.

(signed) Charles C. Stewart, President  
Mercer Medical Center, Trenton

### Physostigmine in Imipramine Cardiotoxicity

May 13, 1977

Dear Sir:

Rushnak and McGovern's case report regarding the successful use of physostigmine in imipramine cardiotoxicity (*J Med Soc NJ* 74: 155-157) is remarkable in that the shortening of the QRS complex was noticed within five minutes of physostigmine administration. I think it is very important to point out that the prolongation of the QRS interval in tricyclic antidepressant poisoning occurs due to slowed conduction in the ventricular conducting tissue<sup>1</sup>, and that a positive correlation exists between the duration of the QRS complex and the plasma tricyclic levels in these patients.<sup>2</sup>

Since the ventricular conduction tissue is poorly innervated with cholinergic fibers, a substantial response to physostigmine is unlikely, as far as the QRS duration is concerned.

Rushnak and McGovern fail to mention the heart rate after physostigmine was given. It is

possible that the decreased QRS duration was secondary to a slowed heart rate induced by the cholinergic actions of physostigmine on the atrial tissues. This indirectly would improve myocardial function in a patient with an intrinsically diseased heart, although the patient's age and past medical history mitigate against such an assumption. In most cases of tricyclic antidepressant overdose, the QRS duration will not be affected to an appreciable degree by physostigmine, so a decreasing QRS duration will represent a decreasing plasma tricyclic level rather than a pharmacologic action of physostigmine.

An intravenous fluid infusion of over six liters in twelve hours is to be deplored. Numerous reports have pointed out the futility of this method<sup>3</sup> and serious complications may result. A negative inotropic effect of imipramine has been observed previously in many *in vitro* and *in vivo* preparations, so it is very easy to precipitate heart failure in these patients with overzealous intravenous infusions. In case a rapid volume replacement is contemplated, in order to combat hypotension precipitated by relative intravascular hypovolemia, a monitor of the pulmonary arterial wedge pressure with a Swan-Ganz catheter may be advisable.

(signed) Shashi K. Agarwal, M.D.

#### References

- <sup>1</sup> Davies B, Burrows G, Dumovic P, *et al*: Effects on the heart of different tricyclic antidepressants; Sinequan (Doxepin HCL): A monograph of recent clinical studies. *Excerpta Medica* 1975.
- <sup>2</sup> Spiker DG, Weiss AN, Chang SS, *et al*: Tricyclic antidepressant: Clinical presentation and plasma levels. *Clin Pharmacol Ther* 18:539-546, 1975.
- <sup>3</sup> Avram MM and McGinn JJ: Extracorporeal hemodialysis in phenothiazine overdose. *JAMA* 197(2):142-143, 1966.
- <sup>4</sup> Aurora S and Lahiri PK: Antiacetylcholine action of imipramine. *Japan J. Pharmacol* 18:509, 1968.
- <sup>5</sup> Van de Ree JK, Zimmerman ANE, and Van Jeijst ANP: Intoxication with tricyclic antidepressants: Hemodynamic consequences. *Eur J Toxicol* 5:302-305, 1972.

#### More on the Effect of Lithium

May 20, 1977

Dear Editor:

I would take issue with Dr. William Layman's statement in his recent article (*J Med Soc NJ* 74:437-440) on the systemic effects of lithium that "serious renal impairment is the only absolute contraindication of lithium therapy."

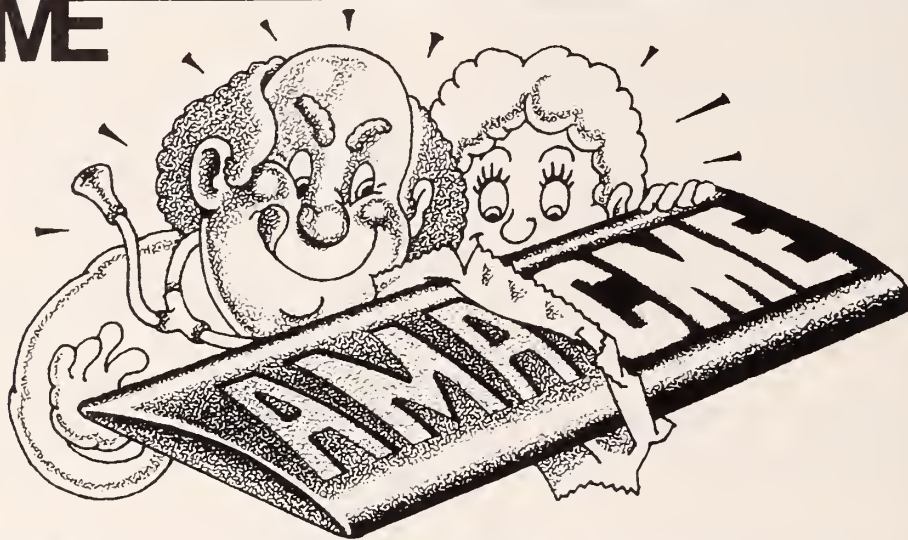
Renal impairment complicates the selection of proper dosage and should alert the physician for extraordinary care but it need not be an absolute contraindication to lithium therapy. The dose of lithium can be properly tailored and since there is available an accurate, quick, and relatively inexpensive test to determine blood levels, lithium therapy can be instituted and maintained in patients with serious renal disease. The selection of medication and tailoring of dosage in patients with serious renal disease do present problems to the treating physician but accommodations are available.

(signed) Lawrence J. Berman, M.D.

#### Helping Hand Organization

Many of the younger physicians do not know that there exists in our State a unique helping hand organization — the Society for the Relief of Widows and Orphans of Medical Men in New Jersey. This organization provides immediate financial assistance to the dependents of a deceased member. It lends money without interest to widows and orphans of doctors who have known adversity. For details, please write to the Society at P.O. Box 95, Belleville, New Jersey 07109.

# CME



## AMA brings CME to Hershey

**AMA Regional CME Program — Nov. 18-19, 1977**

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This meeting has been developed by the AMA in cooperation with Hahnemann Medical School, Jefferson Medical College, Medical College of Pennsylvania, New Jersey Medical School, and the medical schools of Howard University, Penn State University, Rutgers University, Temple University, University of Pennsylvania, University of Pittsburgh, and the Pennsylvania Medical Society.

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#### FRIDAY, NOVEMBER 18, 1977 (Each 6 Hours)

- P-1. Proper Selection of Antibiotics
- P-2. Dermatology for Nondermatologists
- P-3. Medical Ethics: Euthanasia & the Doctor-Patient Relationship
- P-4. Neonatology
- P-5. Financial Management Colloquium (This colloquium **only** is CME Category 2.)

#### FRIDAY & SATURDAY, NOVEMBER 18-19, 1977 (16 Hours)

- P-6. Basic & Advanced Life Support (Cardiopulmonary Resuscitation—CPR)

#### SATURDAY, NOVEMBER 19, 1977 (Each 6 Hours)

- P-7. Alternate Lifestyle
- P-8. Drugs of the Decade
- P-9. Ambulatory Care of Pulmonary Disease
- P-10. Current Advances in the Treatment & Research of Cancer
- P-11. Acid-Base, Fluid, & Electrolyte Balance
- P-12. Auscultation

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## Personal Item

### III Award to Dr. Bernstein

Arthur Bernstein, M.D., of South Orange, added yet another to his long list of awards when he became the recipient of this year's Edward J. III Award for dedication and extraordinary service to the medical profession and to the citizens of New Jersey.

A graduate of the University of Pennsylvania Medical School and a diplomate of the Ameri-

can Board of Internal Medicine (cardiovascular diseases), Dr. Bernstein is Clinical Professor of Medicine, CMDNJ, New Jersey Medical School, and Associate in Cardiology at the University of Pennsylvania Graduate School of Medicine. He has held office in many organizations—county, state, and national—and currently is Secretary of the Medical Society of New Jersey and of its Board of Trustees, and Chairman of the Committee on Medical Education.

### Support the Society for Relief of Widows and Orphans

(P.O. Box 102, Hopewell, N.J.)

## ANNOUNCEMENTS

### Conference on Primary Care

From September 12 to 14 the School of Health Services of the Johns Hopkins University will present a three-day conference on the diagnosis and management of primary care problems. The program is designed to provide continuing education to primary care practitioners and to offer an examination review in preparation for the national board examination for physicians' assistants. Lectures of general interest will be supplemented by seminars on adult, pediatric, gynecologic, and general health care topics.

Approval has been given for sixteen and a half credit hours by both the AMA for Category I and the American Academy of Physicians' Assistants. Fee for the programs on the 12th and 13th is \$75, and for the PA's examination review on the 14th the charge is \$40. Further information is available from the Program Coordinator, Office of Continuing Education,

Room 22, 720 Rutland Avenue, Baltimore, Maryland 21205.

### Seminar on Contemporary Medicine

The 13th Annual Scientific Assembly of the American Society of Contemporary Medicine and Surgery will be held January 30 through February 3, 1978 in Miami Beach. A faculty of 100 will be headed by the ASCMS President, Dr. Michael DeBakey, and the Chairman, Dr. Leon O. Jacobson.

The program will include seminars and tutorials on cardiovascular diseases, hypertension, gastrointestinal diseases, inflammatory bowel disease, cancer, genitourinary diseases, pain, endocrinology, cryosurgery, neuropsychiatric manifestations of systemic disease, acid-base abnormalities, and others, all with panel discussions and question-and-answer sessions.

This continuing medical education offering meets the criteria for 40 credit hours in Category I of the AMA Physician's Recognition Award. For further information please write to John G. Bellows, M.D., Ph.D., Director ASCMS, 6 North Michigan Avenue, Chicago, Illinois 60602 — (312) 236-4673.

### Conferences in Vail

The Conference and Institute Program of the Beth Israel Hospital in Denver, Colorado, has announced the following CME programs for the winter of 1978:

Family Practice Conference, February 11-18

Ob/Gyn Conference, February 18-25

Aspen Radiology Conference, February 25-March 4 (The Aspen Institute for Humanistic Studies, Aspen, Colorado)

Cancer Conference, March 4-11

General Surgery Conference, March 11-18

Internal Medicine Conference, March 18-25

Urology Conference, March 18-25

Meetings are approved for up to 25 hours of AMA Category I credit, depending, of course, on the number of class hours scheduled. Credit also has been applied for at the appropriate specialty colleges. Registration fee is \$190 for each session—\$125 for house officers. For further information please direct all communication to the Beth Israel Hospital Conference and Institute Program, 1818 Gaylord Street, Denver, Colorado 80206.

### Burn Unit Opened at St. Barnabas

A 12-bed burn care facility offering up-to-date techniques and equipment for the treatment of burn victims was opened on April 6 at St. Barnabas Medical Center, Livingston. Provided there is a full range of diagnostic and therapeutic services including shock assessment and treatment, hydrotherapy, hyperbaric oxygenation, and reconstruction and rehabilitation. Patients may be directed to the burn unit itself after clearance for admission by the referring physician or institution with Frederick W. Fuller, M.D., the physician in charge of the unit, telephone 201-533-5920.

### AMNJ Section on Endocrinology

The Academy of Medicine has announced the formation of a section on endocrinology. Initially, roles may overlap those of the Division of Endocrinology and Metabolism of the New Jersey Medical School, but subsequently there will be additional functions under the aegis of the Academy.

Physicians interested in diabetes, endocrinology, and metabolism disorders are urged to join the Academy to participate in the continuing education activities of this new section. Dinner meetings will be held on the first Wednesday of each month, September through May. For information, please write to the Academy of Medicine, 2424 Morris Avenue, Union 07083 — (201) 687-8780.

### Nephrology Society Proceedings

The proceedings of the Fourth Scientific Session of the Nephrology Society of New Jersey, which include abstracts, presented June 7, 1977, of studies on the topics listed below, are available from the Nephrology Society of New Jersey, c/o the Academy of Medicine, 2424 Morris Avenue, Union, New Jersey 07083.

Allergy to a Heparin Preparation in Patient Poisoned by Arsine

Duration of Hepatitis B Surface Antigen in Hemodialysis Patients

Experience with Chronic Peritoneal Dialysis Utilizing the Tenckhoff Catheter

Evaluation of Chronic Peritoneal Dialysis as a Procedure

Relationship of Tubular Immunoglobulin Deposition to Concentrative Transport of <sup>3</sup>H-PAH

Renal Vein Renins and Renal Renin Production Ratios as Predictors of Response to Surgery in Medicated and Unmedicated Hypertensives with Asymmetric Renal Lesions

Micropuncture Study of Maleic Acid-Induced Fanconi Syndrome in Rat Kidney

Dialysis Index: Theoretic Appraisal

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peripheral circulation. Also provides concomitant  
administration of the listed vitamins. The warm  
tingling flush which may follow each dose of LIPO-  
NICIN 100 mg. or 250 mg. is one of the thera-  
peutic effects that often produce psychological  
benefits to the patient. Side Effects: Transient  
flushing and feeling of warmth seldom require dis-  
continuation of the drug. Transient headache, itch-  
ing and tingling, skin rash, allergies and gastric  
disturbance may occur. Contraindications: Patients  
with known idiosyncrasy to nicotinic acid or other  
components of the drug. Use with caution in preg-  
nant patients and patients with glaucoma, severe  
diabetes, impaired liver function, peptic ulcers,  
and arterial bleeding.

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# MEETINGS OF MEDICAL INTEREST

This listing is compiled through the cooperation of the Committee on Medical Education of The Medical Society of New Jersey, the Academy of Medicine of New Jersey, the New Jersey Chapter of the American Academy of Family Physicians, and the Office of Continuing Medical Education of the College of Medicine and Dentistry of New Jersey. For information on accreditation, please contact the sponsoring organization(s), indicated by italics — last line of each item.

## Aug.

- 11 **Pediatric Emergency**
- 18 **Acute Renal Failure**
- 26 **Psychiatric Emergencies**  
11:45 a.m.-12:45 p.m. — Kennedy Medical Center,  
Edison  
(*Kennedy Medical Center and AAFP*)

## Sept.

- 2 **Parkinsonism**  
12 noon-1 p.m. — St. Mary's Hospital, Orange  
(*St. Mary's Hospital and AMNJ*)
- 6 **Community Medicine**  
9:30-10:30 a.m. — Overlook Hospital, Summit  
(*Overlook Hospital and AAFP*)
- 7 **Lupus Erythematosus**  
1-5 p.m. — Jersey City Medical Center  
(*Nephrology Society of N.J. and AMNJ*)
- 13 **Venereal Disease**
- 20 **Hypertension Clinics**
- 27 **Treatment of Hypertension**  
9-10 a.m. — Holy Name Hospital, Teaneck  
(*Holy Name Hospital and AMNJ*)
- 15- **Third Memorial Ignatz Semmelweis Seminar**
- 18 Chalfonte/Haddon Hall, Atlantic City  
(*CMDNJ, AMNJ and AAFP*)
- 16 **Peptic Ulcer**  
11:00 a.m.-12 noon — Ciba-Geigy Pharmaceuticals  
Div., Summit  
(*Ciba-Geigy and AMNJ*)
- 20 **Depression**  
5:30-6:30 p.m. — St. Mary's Hospital, Orange  
(*St. Mary's Hospital and AMNJ*)
- 21 **Internal Medicine and Therapeutics**  
9-11 a.m. — Middlesex General Hospital,  
New Brunswick  
(*Middlesex General Hospital, AMNJ, and AAFP*)
- 21 **Proliferative Retinopathy**  
5-8:30 p.m. — Hunterdon Medical Center, Flemington  
(*Hunterdon Medical Center and AMNJ*)
- 23 **Psychotherapy**  
8-10:30 p.m. — The Manor, West Orange  
(*N.J. Psychiatric Association and AMNJ*)
- 24 **Dedication of New Department of Surgery**  
8:30 a.m.-12:45 p.m. — N.J. Medical School, Newark  
(*CMDNJ and AMNJ*)

- 27 **Adolescent Sexuality**  
8-10 p.m. — Ramada Inn, Clark  
(*Am. Academy Pediatrics, N.J. Chapter and AMNJ*)
- 28 **Occupational Medicine**  
1-5:30 p.m. — Sheraton Inn-Newark Airport, Elizabeth  
(*Rutgers Medical School and AMNJ*)
- 28 **I.V. Hyeralimentation**  
1-3 p.m. — Christ Hospital, Jersey City  
(*Christ Hospital, AMNJ, and AAFP*)
- 29-30 **Annual Meeting** — N.J. Orthopaedic Society
- Oct. 1 Mullet Bay, St. Maarten  
(*N.J. Orthopaedic Society and AMNJ*)

## Oct.

- 3 **Psychiatric Seminar**  
8-10 p.m. — 9 Marquette Rd., Upper Montclair  
(*Essex Psychiatric Seminar and AMNJ*)
- 4 **Community Medicine**  
9:30-10:30 a.m. — Overlook Hospital, Summit  
(*Overlook Hospital and AAFP*)
- 4 **Treatment of Hypertension Diabetes**
- 18 9-10 a.m. — Holy Name Hospital, Teaneck  
(*Holy Name Hospital and AMNJ*)
- 5 **Multidisciplinary Approach to Cancer**
- 12 2-6 p.m. — Newark Beth Israel Medical Center,
- 19 Newark
- 26 (*Newark Beth Israel Medical Center and AMNJ*)
- 5 **Internal Medicine and Therapeutics**
- 12 9-11 a.m. — Middlesex General Hospital,
- 19 New Brunswick
- 26 (*Middlesex General Hospital and AMNJ*)
- 7-9 **Tenth Annual Cardiovascular Conference**  
Chalfonte-Haddon Hall, Atlantic City  
(*American Heart Association, N.J. Affiliate, Inc. and AMNJ*)
- 9 **Sexually Transmitted Diseases**  
10 a.m.-4:30 p.m. — Sheraton, Hasbrouck Heights  
(*Rutgers Medical School and AMNJ*)
- 12 **Dreams in Psychotherapy**  
8:30-10:30 p.m. — Guido's Restaurant, Hackensack  
(*North Jersey Psychiatric Society and AMNJ*)
- 12 **Hyperlipidemia**  
1-3 p.m. — Christ Hospital, Jersey City  
(*Christ Hospital, AMNJ and AAFP*)

- 13 **High Risk Obstetrics**  
12 noon-1 p.m.—St. Mary's Hospital, Orange  
(*St. Mary's Hospital and AMNJ*)
- 14 **Preservation of Ischemic Myocardium**  
11 a.m.-12 noon—Ciba-Geigy, Pharmaceuticals Div.,  
Summit  
(*Ciba-Geigy and AMNJ*)
- 19 **Acute Renal Failure**  
1-3 p.m.—Christ Hospital, Jersey City  
(*Christ Hospital and AMNJ*)
- 19 **Trends in Cardiology**  
10 a.m.-noon and 2:15-4:30 p.m.—Watchung View  
Inn, Bridgewater  
(*Rutgers Medical School, Raritan Valley Hospital,  
and AMNJ*)
- 19 **Updating Peripheral Neuropathy**  
1-2 p.m.—VA Hospital, Lyons  
(*VA Hospital, Lyons, and AMNJ*)
- 20 **Viral Etiology of Cancer**  
1:45-5:30 p.m.—Drew University, Madison  
(*Ciba-Geigy and AMNJ*)
- 26 **The American Diabetes Association**  
All Day—Morristown Memorial Hospital  
(*Morristown Memorial Hospital, AMNJ, and  
American Diabetes Assoc.*)
- 26 **Clinical Hypnosis**  
1-5 p.m.—Ramada Inn, Clark  
(*Rutgers Medical School and AMNJ*)
- 27 **Retropubic Prostatectomy**  
12 noon-1 p.m.—St. Mary's Hospital, Orange  
(*St. Mary's Hospital and AMNJ*)
- 28 **Anti-Psychotic Medications**  
1-2 p.m.—VA Hospital, Lyons  
(*VA Hospital, Lyons, and AMNJ*)
- 29 **Annual Respiratory Care Symposium**  
9 a.m.-1 p.m.—Rutgers Medical School, Piscataway  
(*N.J. State Society of Anesthesiologists and AMNJ*)

Nov.

- 1 **Community Medicine**  
9:30-10:30 a.m.—Overlook Hospital, Summit  
(*Overlook Hospital and AAFP*)
- 2 **Multidisciplinary Approach to Cancer**  
9 2-4 p.m.—Newark Beth Israel Medical Center  
16 (*Newark Beth Israel Medical Center and AMNJ*)  
23  
30
- 2 **Clinical Hypnosis**  
9 1-5 p.m.—Ramada Inn, Clark  
16 (*Rutgers Medical School and AMNJ*)
- 2 **Internal Medicine and Therapeutics**  
9 9-11 a.m.—Middlesex General Hospital,  
16 New Brunswick  
23 (*Middlesex General Hospital and AMNJ*)  
30
- 4 **Gastrointestinal Hormone Assay**  
12 noon-1 p.m.—St. Mary's Hospital, Orange  
(*St. Mary's Hospital and AMNJ*)
- 7 **Psychiatric Seminar**  
8-10 p.m.—4 Garden Place, Nutley  
(*Essex Psychiatric Seminar and AMNJ*)
- 12 **Family Therapy**  
9 a.m.-5 p.m.—Holiday Inn, Livingston  
(*N.J. Center for Family Studies and AMNJ*)

Dec.

- 5 **Psychiatric Seminar**  
8-10 p.m.—192 Chittenden Rd., Clifton  
(*Essex Psychiatric Seminar and AMNJ*)
- 6 **Community Medicine**  
9:30-10:30 a.m.—Overlook Hospital, Summit  
(*Overlook Hospital and AAFP*)
- 7 **Multidisciplinary Approach to Cancer**  
14 2-4 p.m.—Newark Beth Israel Medical Center  
21 (*Newark Beth Israel Medical Center and AMNJ*)

## OBITUARIES

### Dr. Joseph E. Bossone

One of Monmouth County's senior members, Joseph E. Bossone, M.D., of Long Branch died on May 5 in North Ridge Hospital, Fort Lauderdale, Florida. Dr. Bossone earned his medical degree from the University of Naples in 1931 and pursued graduate studies in surgery at George Washington University and Columbus

Hospital in New York. He then accepted appointment (1934) as attending surgeon at Monmouth Memorial Hospital (now Monmouth Medical Center) and also served as secretary of the medical board of the hospital and chairman of the emergency room committee. Dr. Bossone was interested in medical affairs and long represented his county in MSNJ's House of Delegates. In the 1940's and 1950's he was Long Branch city physician and surgeon. He was a member of the American Society of Abdominal Surgeons. Dr. Bossone was 71 years old at the time of his death.

#### Dr. William Braun

A member of our Camden County component, William Braun, M.D., died on May 25 at Cooper Medical Center in Camden. Born in 1907 and graduated from Jefferson College of Medicine, class of 1934, Dr. Braun pursued graduate work in ophthalmology and practiced that specialty in the Camden area for many years. He was a diplomate of the American Board of Ophthalmology and a Fellow of the American Academy of Ophthalmology and Otolaryngology. Dr. Braun had been senior attending in the department of ophthalmology at Cooper Medical Center.

#### Dr. John Coniaris

At the untimely age of 54, John Coniaris, M.D., a member of our Essex County component, died at St. Michael's Medical Center, Newark, where he long had been a member of the staff. A graduate of New York Medical College, class of 1950, Dr. Coniaris pursued a career in cardiology, ultimately becoming director of that department at St. Michael's. In addition he was chairman of the Medical Center's committee on graduate medical education, secretary of the medical staff, and a trustee of its heart research institute. Dr. Coniaris also was a member of the staff at St. Mary's Hospital in Orange and at Overlook Hospital in Summit. He was a Fellow of the American College of Angiology and a member of the American Geriatric Society.

#### Dr. Michael N. Coplin

The promising career of Michael N. Coplin M.D., ended on May 26 when he died in St. Elizabeth Hospital, Elizabeth, after suffering an apparent cerebral hemorrhage. A native of New Jersey, Dr. Coplin was graduated from the University of Maryland's School of Medicine in 1965 and pursued a residency in psychiatry at St. Vincent's Medical Center in New York. He was affiliated with Alexian Brothers, Elizabeth General, and St. Elizabeth Hospitals, and had organized the alcoholism detoxification center at Runnells Hospital in Berkeley Heights. Dr. Coplin was 39 years old.

#### Dr. Millard Cryder

At the grand age of 86, Millard C. Cryder, M.D., a leading Cape May physician, died at his home on May 7 after a long illness. A graduate of Jefferson Medical College, class of 1920, Dr. Cryder practiced family medicine, and had been associated with the Burdette-Tomlin Hospital as a member of the active staff and its first president. He had served a term as president of his county medical society and was instrumental in forming the blood bank for Cape May Court House, Wildwood, and Cape May. He was active in the local community, having been school physician for Avalon and Stone Harbor and for twenty years a member of the board of directors of the Woodbine State School. Dr. Cryder served his country in both World War I and World War II, receiving, in the latter instance, a citation for meritorious service. In 1970 he was a recipient of MSNJ's Golden Merit Award, indicating fifty years of medical practice.

#### Dr. David Doktor

David Doktor, M.D., a member of our Passaic Medical Society, was brutally murdered in front of his office as he attempted to answer an emergency call to Barnert Memorial Hospital in the early morning hours on May 27. A native of Paterson, born in 1912, Dr. Doktor was graduated from Indiana University School of Medicine in 1936 and practiced family medicine in his home community for many years. He was on staff at Barnert Memorial Hospital.

#### Dr. Millard B. Ervin

We just have learned of the death of Millard B. Ervin, M.D., on March 15 at Bay Shore Community Hospital in Holmdel. An emeritus member from the Essex County Medical Society, Dr. Ervin was graduated from Long Island University College of Medicine in 1919 and had practiced general medicine in Westfield until retirement in 1953. Recently he had been living in Eatontown. Dr. Ervin was 83 years old at the time of his death.



#### **Dr. Salvatore Ferrari**

A member of our Passaic County Medical Society, Salvatore T. Ferrari, M.D., who formerly practiced ophthalmology in Paterson, died on May 14 after a long illness. Born in 1900 and graduated from Cincinnati Eclectic Medical College in 1938, Dr. Ferrari took residencies in ophthalmology at the Jersey City Medical Center and at the Newark Eye and Ear Infirmary. He had been chief of ophthalmology at St. Joseph's Hospital in Paterson, and had staff appointments at the Medical Center in Jersey City and Martland Hospital in Newark. Dr. Ferrari was an associate clinical professor at the College of Medicine and Dentistry of New Jersey and a Fellow of the International College of Surgeons.

#### **Dr. James A. Fisher**

One of Monmouth County's senior members, James A. Fisher, Sr., M.D., died on June 5. A graduate of Syracuse University Medical School in 1915, Dr. Fisher took residencies in ophthalmology at New York Ophthalmic and New York Postgraduate Hospitals. He was a diplomate of the American Board of Otolaryngology and a Fellow of the American Academy of Ophthalmology and Otolaryngology and of the American College of Surgeons, as well as a member of the Academy of Medicine of New Jersey. He had been director of the EENT department at Fitkin Memorial Hospital (Jersey Shore Medical Center) for 25 years, and held the same post at Monmouth Medical Center in Long Branch for 15 years. He also was affiliated with Paul Kimball Hospital in Lakewood and the Allenwood Sanatorium. Dr. Fisher had been retired since 1970. His avocation as a painter ended three years ago when he became blind as the result of a brain hemorrhage. He had donated some forty of his works to Jersey Shore Medical Center and many still are hanging there. In 1965 Dr. Fisher was a recipient of MSNJ's Golden Merit Award. He was 86 years old at the time of his death.

#### **Dr. William T. Knight**

William Thomas Knight, M.D., of Paramus, a former president of the Bergen County Medical Society, died on May 31. Born in 1905 and

graduated from New York University Medical School, class of 1933, Dr. Knight pursued a residency in surgery at Bellevue Hospital, New York. He had been senior attending surgeon at Hackensack Hospital and assistant director of the surgical department at Bergen Pines County Hospital in Paramus. He was active in civic affairs in Bergen County and had been school physician to the town of Oradell for twenty years. Dr. Knight was a member of the American Radium Society and the International College of Surgeons.

#### **Dr. Fulton Massengill**

Word has just been received of the death on March 18 in Overlook Hospital, Summit, of Fulton Massengill, M.D., a member of the Essex County Medical Society, recently living in Short Hills. Born in 1904, Doctor Massengill was graduated from St. Louis University Medical School in 1930. Retired since 1968, he had pursued a career in industrial medicine and some years ago had been chairman of the department of rehabilitation and physical medicine at St. Barnabas Medical Center, Livingston. He was a member of the Industrial Medical Association and of the Academy of Medicine of New Jersey.

#### **Dr. Frank P. Pignataro**

Frank P. Pignataro, M.D., a member of our Monmouth County component, died on May 28 after a lengthy illness. A 1935 graduate of Georgetown University School of Medicine, he pursued graduate studies in neurology and psychiatry. He was board certified in his chosen field and a Fellow of the American Psychiatric Association and of the American College of Physicians. He had been on staff at the Monmouth Medical Center in Long Branch and Riverview Hospital in Red Bank. He was the author of a number of published scientific articles, notably a series on military psychiatry which appeared in *The Military Surgeon*. He was a past-president of the New Jersey Neuropsychiatric Association and held the same position in the New Jersey branch of the American Psychiatric Association. He also was a past-president and member of the board of managers of the Arthur Brisbane Child Treatment Center.

Dr. Pignataro was 68 years old at the time of his death.

#### **Dr. Reginald F. Seidel**

Reginald F. Seidel, M.D., a member of the Bergen County Medical Society formerly from Englewood, died on May 3 at his home, Quidnet, Nantucket, Massachusetts. Born in 1913 and graduated from Long Island University College of Medicine, class of 1939, Dr. Seidel was senior attending urologist at Englewood Hospital and associate director of that department at Bergen Pines County Hospital in Paramus. He also had been affiliated in the urology section at Presbyterian Hospital in New York City. He was board certified in his chosen field and was a Fellow of the American College of Surgeons.

#### **Dr. Alex Stone**

The assistant medical director at the Marlboro Psychiatric Hospital, Alex Stone, M.D., of Colts Neck, died on May 5 after a short illness. Born in Latvia in 1911 and graduated from the University of Basel, Switzerland in 1939, he came to the United States two years later for further training and took residencies in medicine at Alexian Brothers Hospital in Chicago and St. Francis Hospital in Peoria. He practiced in Illinois until pursuing a further residency in psychiatry at the New Jersey State Hospital in Marlboro beginning in 1955. Dr. Stone was a Fellow of the American Psychiatric Association and a member of the New Jersey Psychiatric Association and of the Association for the Advancement of Science.

#### **Dr. Alice E. Tyndall**

Alice E. Tyndall, M.D., who formerly practiced in Westfield, died on May 12 at Overlook Hospital in Summit. A native of Vermont, Dr. Tyndall was graduated from the University of Vermont Medical School, class of 1933 and practiced general medicine in Westfield until her retirement in 1964. She had been on the staff at Rahway Hospital and Muhlenberg Hospital in Plainfield. Dr. Tyndall was a member of the American Academy of Family Practice and the American Medical Women's Association.

#### **Dr. Frederick vonHofe**

One of Essex County's emeritus members, Frederick H. vonHofe, M.D., formerly of the Oranges, died at his home in Hackettstown on May 12, after a long illness. Born in 1891 and graduated from Columbia University's College of Medicine in 1917, Dr. vonHofe practiced pediatrics, with special interest in pediatric hematology, until his retirement in 1965. He had been on the staff at St. Barnabas Medical Center in Livingston, Babies' Hospital in Newark, and Memorial Hospital in Orange. Dr. vonHofe was a diplomate of the American Board of Pediatrics and a member of the American Academy of Pediatrics. In the 1950's he had been an instructor of pediatrics at Columbia University and had been affiliated with Babies' Hospital in New York City.

#### **Dr. Stanley O. Wilkins**

One of Essex County's senior members, Stanley O. Wilkins, M.D., died on March 8 at the Veterans Administration Hospital in Lyons. Born in 1904, and graduated from Hahnemann Medical College, class of 1933, Dr. Wilkins studied further at the University of Pennsylvania Graduate School of Medicine and went on to practice surgery in Monmouth County for many years. He had been on the surgical staff, specializing in traumatic surgery and fractures, at Monmouth Medical Center, Long Branch, Jersey Shore Medical Center, Neptune, and Riverview Hospital, Red Bank. He retired from private practice in 1969 and continued to participate as county medical examiner and physician to Monmouth College in West Long Branch. During World War II, Dr. Wilkins served three years with the department of medicine of the United States Army.

#### **Dr. James L. York**

James L. York, M.D., a member of our Bergen County component, died on May 31 in North Palm Beach, Florida where he had retired in 1971. A graduate of Jefferson Medical College, class of 1930, Dr. York practiced general medicine in New Milford, New Jersey for many years and had been on the staff at Holy Name Hospital in Teaneck. During World War II Dr. York served for three years in the medical department of the United States Army.

# BOOK REVIEWS

**An Annotated Checklist of Osleriana.** E. E. Naton, C. G. Roland, J. F. McGovern. Kent, Ohio, The Kent State University Press, 1976. (\$27.50)

At his death in 1919 Sir William was universally regarded as the most famous of contemporary physicians. So great was his prestige that memorial services in his honor were held not only in the leading centers of Europe and America but in far distant lands where he also was revered. Now, more than a century later, the cult of Osler admirers shows no signs of abatement, and indeed seems to have reached an all-time high, with vigorous Osler societies flourishing throughout the English-speaking world. Every fragment of the master's voluminous writings, no matter how insignificant, is now being avidly collected, and booksellers have done very well by catering to this passion for Osleriana.

What sort of a man was this Osler, wherein lay his charisma during his lifetime, and how has his name managed to retain its phenomenal fascination over passing generations? These are some of the questions which the editors of the volume under consideration have made a valiant and quite successful attempt to answer. In an unusual tribute to the man they so greatly admire they have compiled a list of no less than 1367 articles, essays, eulogies, and biographical studies which illuminate every facet of Osler's life, personality, and accomplishments. From now on anyone seeking to uncover the "true Osler" will find this book, with the editorial comments on each entry, an invaluable tool.

While not underestimating the significance of Osler's purely medical writings it is becoming increasingly clear that his appeal to the present generation stems largely from his stature as a man of letters and culture. A devoted student of medical history, when interest in this subject was virtually non-existent in America, Osler converted a host of disciples to his avocation. An ardent bibliophile he built a remarkable collection of medical classics which now add lustre to McGill, his alma mater. It is safe to say that the monumental *Bibliotheca Osleriana*, a work of his last years takes equal pride of place with *The Principles and Practice of Medicine* as the two most lasting contributions of this gifted individual.

Morris H. Saffron, M.D.  
Archivist-Historian, MSNJ

**Mind As Healer, Mind As Slayer.** Kenneth Pelletier. New York, Dell Publishing, 1977. Pp. 366. (Paperback — \$4.95)

Why do so many physicians cast aside the vast powers of the mind in their practice of the art of medicine? Symptoms can be controlled using such psychological techniques as operant conditioning methods, and there has been research and an enormous amount of literature collected dealing with bringing about the regression of cancer.

This book defines the role of stress in four major types of illness: cardiovascular disease, cancer, arthritis, and respira-

tory disease. It is divided into three main parts which discuss the nature of stress; the relationship between stress and disease; and methods of controlling stress. This latter section is excellent inasmuch as it discusses various techniques such as meditation, biofeedback, and autogenic training and visualization.

Although the book appears to have been written primarily for general popular consumption, the theme of holistic medicine is one that the general physician should learn. This book is highly recommended.

Seymour F. Kuvin, M.D.

**B. T. Behavior Therapy: Strategies for Solving Problems in Living.** Spencer A. Rathus and Jeffrey S. Nevid. New York, Doubleday, 1977. Pp. 314. (\$8.95)

This reviewer is not quite certain whether his book is serious in its goal or is a farcical "put-on." The approach is one of homey advice on how to resolve everyday problems. The methods described, however, are so primitive that it is believed that they are directed at a reader with a mental age of ten.

Typical of the grandmotherly advice are such instructions as "non-genital massage will obviously be more pleasurable if both parties have recently showered or bathed." In another area, after going through a therapeutic technique to break the cigarette-smoking habit, a statement is made: "The recidivism rate in all types of anti-smoking programs is approximately 80 percent within one year of treatment termination."

One does not need to purchase a book to learn about job seeking skills as stated; "Contact a number of friends and ask them if they are aware of any openings in your field. Make a list of the assets and liabilities you would bring to a new job."

From a behavioristic point of view, the reviewer cannot recommend this book.

Seymour F. Kuvin, M.D.

**Healthy Pregnancy the Yoga Way.** Judi Thompson. New York, Doubleday, 1977. Pp. 148. Illustrated. (Softback — \$3.95).

This book is related to the use of Yoga exercises during pregnancy and in the postpartum period. The techniques described are easy to understand and the illustrative photographs are good. I found the exercises to be very similar to standard prepared childbirth methods. I see no conflict between Yoga and these methods. They could be complementary. The book is an interesting contribution to the subject of exercise in pregnancy.

Unfortunately, the author has not limited her subject to that of the Yoga exercises. She also discusses nutrition in pregnancy and contraception. I would have preferred that the author advise the expectant mother to consult with her physician for advice on these subjects. The nutrition section is incomplete and the vegetarian aspects are over emphasized. It is disturbing to find, in a modern publication, the statement of an old erroneous concept — "some women are particularly sensitive during pregnancy and must eliminate salt from their diets completely." When discussing iron in the diet, the author fails to mention a most important item



—the need for iron supplement during pregnancy regardless of the type of diet.

The last chapter of the book entitled, "A Post-Natal Post-script" is devoted to the author's strong advocacy of a little-known method of contraception, the "ovulation method." It is based on the pattern of cervical mucus. The author states that this way of contraception is 100 per cent accurate. Anybody with some knowledge of contraception realizes the fallacy in this over-enthusiastic statement. The author fails to discuss or even mention the conventional methods of contraception available to men and women.

If the author had limited her subject matter to that of the yoga exercises, I could have recommended the book without hesitation.

M. A. Pelosi, M.D.

**Choose Your Baby's Sex.** David M. Rorvik and Landrum B. Shettles. New York, Dodd, Mead, 1977. Illustrated. pp. 185 (\$7.95)

The present book seems to represent a rewriting of a 1970 hard-cover edition of *Your Baby's Sex: Now You Can Choose*. Doctor Shettles has been promoted from collaborator to co-author. The style is definitely journalistic and thus directs its appeal to the laity who wish to choose the sex of their anticipated babies. The basis for the instructions for such couples is Shettles' claim that he can differentiate "small, round-headed sperm carrying Y chromosomes" from the "larger, oval-shaped type carrying X chromosomes." Since the "androsperms" are purportedly more numerous, more motile, and less resistant to acid than the "gynosperms," the husband who wishes a son should avoid jockey shorts, drink coffee, and avoid coitus until the actual time of ovulation. His wife should take a pre-coital alkaline douche, assume the knee-chest during coitus and seek simultaneous orgasm. The husband who wishes a daughter should wear jockey shorts, avoid coffee, take a pre-coital hot bath, and engage in coitus only until two or three days prior to ovulation while his wife should take a pre-coital acid douche, avoid orgasm, and assume a supine position during coitus unless her uterus is retroverted. These instructions and admonitions which are explained in detail are basically harmless and inexpensive. If the couples are sufficiently mature to accept the 85 percent success rate, it would be unnecessary to involve them in any controversy over the validity of Shettles' claim and theory. However, physicians are obligated to evaluate critically and scrutinize carefully all claims of medical discovery or break-through. The morphologic differences between "androsperms" and "gynosperms" have not been accepted widely or confirmed. This book is not recommended as a serious scientific work.

Jerome Abrams, M.D.

**The Multiple Sclerosis Diet Book.** Ray L. Swank, M.D. and Mary Helen Pullen. New York, Doubleday, 1977. Pp. 326. (\$8.95)

At the invitation of Dr. Wilder Penfield, in August 1948, Dr. Swank undertook research into a single disease entity, multiple sclerosis. Three clues to the disease, the suddenness of relapses suggesting a vascular basis, the geographi-

cal variation of frequency, and post-World War II nutritional studies suggesting a possible correlation between high-fat intake and high frequency of multiple sclerosis led to the introduction of the author's low-fat diet in December 1948.

The book reviews the current theoretical etiological bases for multiple sclerosis including the infectious theory with current interest focused on the measles virus, the autoimmune hypothesis reviewing the EAE studies as well as the lipid imbalance hypothesis upon which the diet is predicated. Because of the correlations between frequency distribution of multiple sclerosis and populations consuming high solid fat (dairy-meat) contrasted to those who eat mainly liquid fat (fish-vegetable oils) i.e., saturated vs. polyunsaturated lipids the recommended diet is a low solid-fat diet that corresponds very much to the diets currently recommended to maintain low cholesterol, low animal fat for heart disease and stroke.

The authors claim a decrease in relapse rate for patients on a low-fat diet of about 95 percent. Two hundred and twenty-five pages of the book are devoted to specifics of menus and recipes. Dr. Swank's recipes exhibit a gourmet's touch.

Ira S. Ross, M.D.

#### Symposium on Medical Malpractice Crisis

The *Maryland Law Review* announces the publication of its symposium, "The Medical Malpractice Crisis," which focuses on medical malpractice reform and alternatives to the present system under the following topics:

Medical Malpractice Reform

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Contracting for No-Fault Liability Insurance Covering Doctors and Hospitals

PSRO—An Alternative to the Medical Malpractice System as a Quality Assurance Mechanism

Copies (\$2.50) may be obtained from the *Maryland Law Review*, University of Maryland School of Law, 500 West Baltimore Street, Baltimore, Maryland 21201.

#### New Edition of AMA Professional Standards Book

*Opinions and Reports of the Judicial Council*, a compilation of interpretations, opinions, and statements of the American Medical Association's Judicial Council, concerning application of the AMA's Principles of Medical Ethics to the everyday practice of medicine, is available from the Order Department, AMA, 535 North Dearborn Street, Chicago 60610. The chapters in this new edition deal with physician responsibilities to the public, patient relations, medical responsibilities, office practices, interprofessional relations, and hospital relations. Reflecting changing times, included are items on human experimentation in medical research, helping patients and families cope with terminal illness, the definition of death, and new medical technology. In other discussions it is stated that physicians "have an ethical duty to subordinate financial reward to social responsibility" and "ability to pay should be considered in reducing fees . . . excessive fees are unethical."

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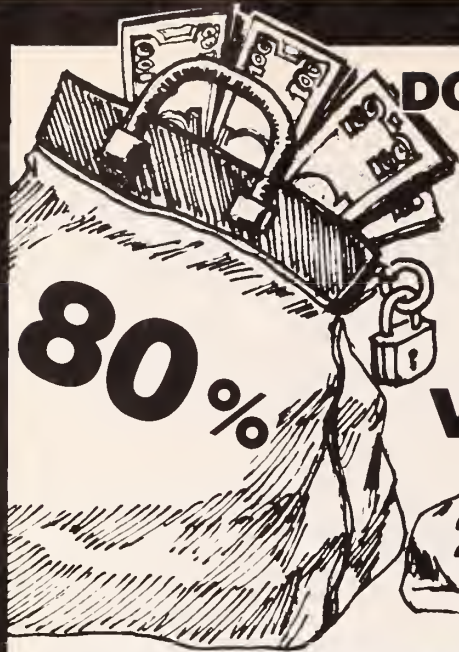
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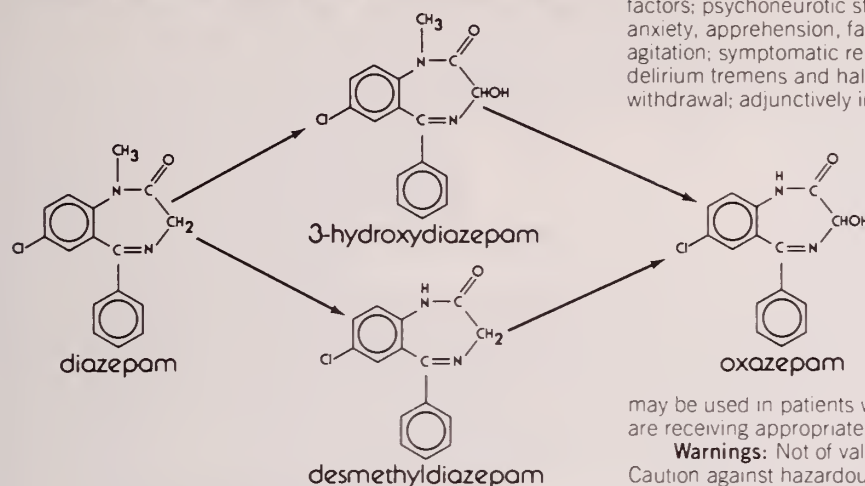
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tension and anxiety

Before prescribing, please consult complete product information, a summary of which follows:

**Indications:** Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

**Contraindicated:**

Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma;

may be used in patients with open angle glaucoma who are receiving appropriate therapy.

**Warnings:** Not of value in psychotic patients.

Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

**Usage in Pregnancy:** Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

**Side Effects:** Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

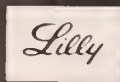


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## EDITORIALS

### Don't Let It Happen to You

Those were the words of advice from a general practitioner in a seaside village near Portsmouth, England, a two-hour drive from London. That plea came from a physician who loves his nation and its history, his community and its people, his profession and its ideals. He believes that all citizens are entitled to good health care, but after almost three decades of practice under the British National Health Service, he is disillusioned, frustrated, and uncertain about his future.

On a recent visit to England, your editor had an opportunity to view the picture of health care through conferences with general practitioners, consultants, nurses, office personnel, patients, the directors and the staff of two voluntary health agencies, a medical student, and the former Deputy Chief Medical Officer of the Department of Health and Social Security. The British Medical Association was in session and the London papers were saturated with accusations and counter opinions:

"Hospital consultants call for one-day strike as pay protest." (*The London Times*)

"Mr. Ennals, Secretary of State for Social Services, described the strike call as deplorable and pointless." (*The London Times*)

"Pay: Doctors Want £14,000" (*London Evening News*)

"Doctors Dismiss New Pay Policy" (*The Guardian*)

Mr. Anthony Grabham, spokesman for the consultants at the British Medical Association, described government dealings with the medical profession as a "catalogue of broken promises" and concluded that "declining morale, serious pay anomalies, and injustices are a damning indictment of the effects of the government's pay policy."

Aside from physician income, the professionals expressed broader concerns. The consensus was that the United Kingdom health system, which is hovering on the brink of collapse, was based on incorrect assumptions. It has been so expensive, so top-heavy with paid admin-

istrators, so short of health workers, so cumbersome due to bureaucratic controls and never-ending regulations, and so prone to political manipulation by the party in power (the Laborites) and the opposition (the Conservatives) that it has satisfied no one and disturbed many. It has produced superior care for few and mediocre health services for most.

A commentary article in this (p. 785) and future issues of *The Journal* will discuss the British National Health Service in greater detail. A.K.

### Fluorescein Angiography

As students, most primary physicians learned to use the ophthalmoscope and felt privileged to get a glimpse in this unusual way of a part of the body's innards. This is not mere curiosity, for the contents of that remarkable extension of the central nervous system give us clues to both local problems and systemic diseases. Thus, via a careful inspection through the dilated pupil, we garner information about diabetes, hypertension, leukemia, and a long list of other problems, and are able to utilize that information for the good of the patient.

It wasn't until photographic techniques had advanced to the point where fluorescein angiography (see related article, page 735) became readily available, that we realized how much more there was to be seen clinically. Ophthalmoscopy gives a static single dimension image, so it is a glimpse at the tip of an iceberg compared to fluorescein studies of the retina. Like angiography in other parts of the body, including the heart, vascular studies of the inner eye show us structure and function and pathology in a living organ with a minimum risk of morbidity and virtually no mortality. Thus, therapy can be planned, prognosis can be determined, and research can be enhanced.

We have not reached the point where every community has a retina laboratory which uses angiography, but every physician should be aware of this procedure and every patient in whom the study is indicated can avail himself of it through reasonably close facilities in New Jersey. A.K.

## Who Is Prescribing For Whom?

A judge of the Superior Court of New Jersey recently committed a mentally ill patient to one of our state psychiatric hospitals and specifically ordered the following treatment:

1. Individual psychotherapy on a one-to-one basis for not less than fifty continuous minutes per week.
2. Trilifon\*, eight milligrams two times a day.
3. Place the patient in a "work release" type program.

On the face of the order, it seems quite reasonable, but the question to be answered is a major one. By what right does a judge order a hospital staff to provide such specific treatment? The staff was given options in terms of dose modification or the type of drug, but nevertheless, the order was so written that the origin of the treatment appears to be the court.

Chief Justice Warren E. Burger of the United States Supreme Court recently warned the American Bar Association that there is a danger that our country might be "overrun by hordes of lawyers hungry as locusts competing with each other, and brigades of judges in numbers never before contemplated." He deplored the interposition of lawyers, judges, and courtrooms into virtually every problem in our society. It already has been crystal clear that the legal profession and the courts are involved deeply in the practice of medicine, but it now appears that medical treatment is not beyond legal prescription.

The Laetrile issue exemplifies the same question, i.e., who is prescribing and for whom? It must be clear to the world by now that amygdalin, the drug obtained from apricot pits, is being promoted by the purveyors of quack nostrums as were all the thousands of fake cures which preceded it. But, there is now a difference—a major and alarming one. In the name of humanity, freedom of choice, and consumerism, the promoters of this material have induced more than a half dozen state legislatures "to permit doctors to prescribe Laetrile," despite the ban by the FDA, and the

condemnation of its use by the AMA and the American Cancer Society. There is no scientific proof of the efficacy of amygdalin—nor its safety—yet many physicians seem ready to take a position that is being foisted upon them which is contrary to all of their training and knowledge.

To use the argument that one should not deny a terminal cancer patient his every wish—including Laetrile—is a great step backward. How does the physician, who prescribes a useless, potentially harmful material to such a desperate individual, avoid the ultimate request by such tragic victims (or their families)—"Doctor, I can't stand it, take my life away!"

There can be little doubt that the real danger of Laetrile is not that a few patients will be disappointed or that physicians and the medical profession will be embarrassed. The threats are:

1. That physicians are being forced into the prescription of unscientific and potentially harmful treatments by unscrupulous merchants of nostrums, by naive politicians and state legislators, by the lunatic fringe who clamor for "freedom of choice," (even if it kills them) and by the consumer advocates whose zeal tends to overwhelm their facts.
2. That the entire system of scientific drug testing for safety and efficiency will be bypassed. No matter how cumbersome it may seem, the present system of drug testing is better than no system.
3. That innocent cancer victims will select a useless method of treatment which has been made available to them through public relations and will not avail themselves of surgery, radiation therapy, and chemotherapy until their disease becomes incurable.
4. That the philosophy that one should acquiesce to the wishes of a terminal patient with the notion that the material can do no harm, so one should not withhold it, is a major step toward euthanasia.

The doctor who has been a *physician* to his patient ought to be able to cope with terminal cancer in more scientific and humane ways than to prescribe a phony cure. If he can do nothing more, he can stand at the bedside and hold the patient's hand.

Before one mindlessly accedes to this horrendous pressure, he should reflect long and deeply into its true meaning to the patient and the doctor, to their relationship, and to the future of medicine.

A.K.

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## New Double-Blind Study ANDROID-25 vs. Placebo\*

\* **WRITE FOR REPRINT:** R. B. Greenblatt, M.D., R. Witherington, M.D.; I. B. Sipahoglu, M.D. *Hormones for Improved Sexuality in the Male and Female Climacteric, Drug Therapy*, Sept. 1976.

Is there a true aphrodisiac? How effective are androgens in the management of the male climacteric and male impotence? Article discusses the psychophysiological and hormonal changes in the elderly male and female and therapeutic considerations. The effectiveness of methyltestosterone in the management of male impotence was confirmed by a cross-over, double-blind study using a placebo and Android-25

(methyltestosterone 25 mg.), on 20 males, 50 years of age or older who complained of secondary impotence. Patients received a series of placebo then Android-25, or Android-25 then placebo as follows: 1 tablet/30 days; 2 tablets/30 days; 3 tablets/30 days. Sexual response was evaluated: 0 = no change; + = 25% improvement; ++ = 50% improvement; +++ = 75% improvement. Placebo effectiveness was + or ++ in 12.7% of trials. Android-25 elicited a +, ++ or +++ response in 47.2% of trials. There was often a dose related response not observed with the placebo. This effect was not observed in younger patients (age 28-45 years).

**DESCRIPTION:** Methyltestosterone is 17 $\beta$ -Hydroxy-17-Methylandro-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-pubertal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

**REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. In the male: Eunuchoidism and eunuchism, 10 to 40 mg. Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg. Postpubertal cryptorchidism, 30 mg. **REFERENCE:** Robert B. Greenblatt, M.D., and D. H. Perez, M.D.: "The Menopausal Syndrome," *Problems of Libido in the Elderly*, pp 95-101 Medcom Press, N.Y., 1974. **HOW SUPPLIED:** 5, 10, 25 mg in bottles of 60, 250. Rx only.

# ORIGINAL ARTICLES

*The technique of fluorescein retinal angiography is a vital and dynamic adjunct in the diagnosis, documentation, followup, and treatment of a great number of retinal and choroidal problems. It should be utilized whenever it is necessary to delineate and to clarify any suspicious ophthalmoscopic abnormalities.*

## Fluorescein Angiography of the Retina\*

**Joseph C. Patti, M.D., Irvington**  
**Alphonse A. Cinotti, M.D., Newark**

Fluorescein retinal angiography was introduced into clinical ophthalmology in 1961 by Novotny and Alvis.<sup>1</sup> The technique consisted of fundus photography using various filters to capture the images on highly sensitive black and white film. It is the purpose of this report to provide an overview of this technique with specific applications in ophthalmic and systemic disease as reflected in the retina.

### Characteristics of Fluorescein Sodium

Fluorescein is one of many substances which upon exposure to light of short wave lengths will emit light of longer wave lengths; hence the term fluorescence applies. This property of the dye has enabled ophthalmologists to study the natural history of a wide range of chorioretinal disorders. It is an adjunct to therapy because it allows visualization of fundus changes which would be difficult to delineate with conventional ophthalmoscopic techniques.

### Side Effects

Fluorescein is excreted in the urine and bile with no metabolic changes. The urine turns orange or yellow immediately and remains so for 24 to 48 hours. Side effects after intravenous injection of fluorescein are rare and mostly harmless.<sup>2</sup> Nausea occurs in one-tenth of one to five percent of patients and vomiting is uncommon. When either of these symptoms occurs it develops within a minute or so after the injection and disappears within 30 seconds to a minute. Extravasation of dye around the injection site may cause discomfort with a localized reaction which subsides within a day or so. Allergic reactions such as urticaria and anaphylaxis are rarely seen; psychogenic syncope occasionally occurs.

### Technique

The technique of fluorescein angiography has not changed basically since its inception. The study is done on outpatients in the doctor's office or clinic. An explanation of the possible side effects is made to the patient and any allergic history noted. The patient is then seated at the camera and the study performed (Figure 1). A rapid intravenous antecubital injection of either 10 cc of a five percent fluorescein solution or five cc of a ten percent solution is made. The dye passes to the eye within eight to thirteen seconds and its passage is photographed. A blue filter is used as an exciter to elicit the fluorescence and a yellow filter as a barrier to permit transmission of only the greenish yellow fluorescence to high speed black and white film. Many different filter combinations have been used in order to elicit the greatest contrast. Many modifications in fundus camera design have also been made to permit either rapid manual advancement of the film or extremely rapid advancement utilizing motor-driven units which are capable of up to four frames per

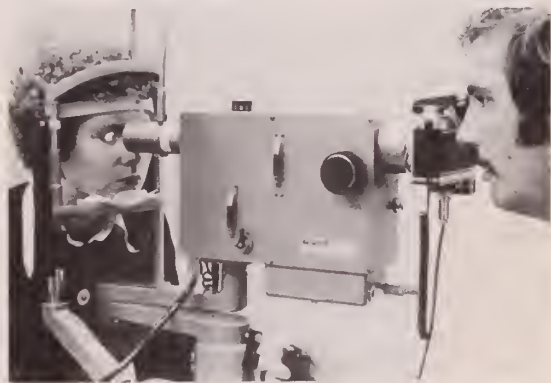


Figure 1 — Patient is seated at the fundus camera in preparation for fluorescein angiography.

\*This report is from the Department of Ophthalmology, New Jersey Medical School and its affiliates, the Eye Institute of New Jersey and the Newark Eye and Ear Infirmary.



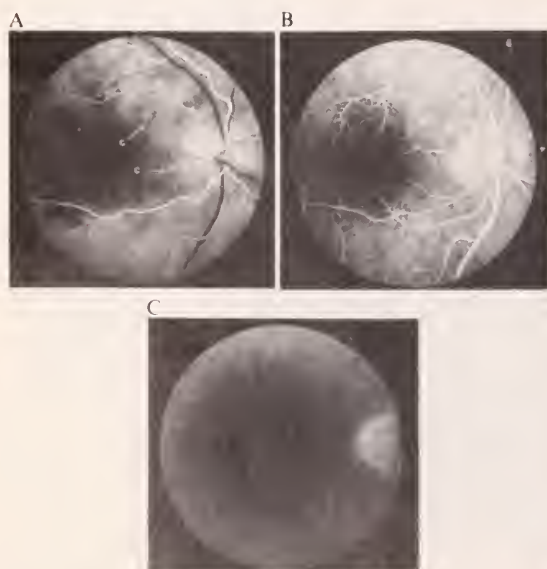
second. More recently a low light level system utilizing television has been employed; this may, in time, prove to be the ultimate technique, since it is well tolerated, shows the complete cycle of dye through the fundus, and eliminates the problems with the processing of the film.

### Angiographic Studies

The normal fluorescein study is seen in Figure 2. The dye passes first into the choroid which has a mottled appearance (A). The retinal arterial phase is noted in (B), and the venous phase in (C). Later phases show the dye passing out of the retina as evidenced by the lack of contrast and paleness of the vessels.

### Diabetic Retinopathy

Fluorescein angiography is especially useful in evaluation of various stages of diabetic retinopathy which may be classified as non-proliferative and proliferative. In this way the capillary bed can be visualized and the neovascular areas outlined. Increased capillary permeability in the non-proliferative stage and neovascularization in the proliferative stage are especially important causes of diminished vision in the diabetic patient.



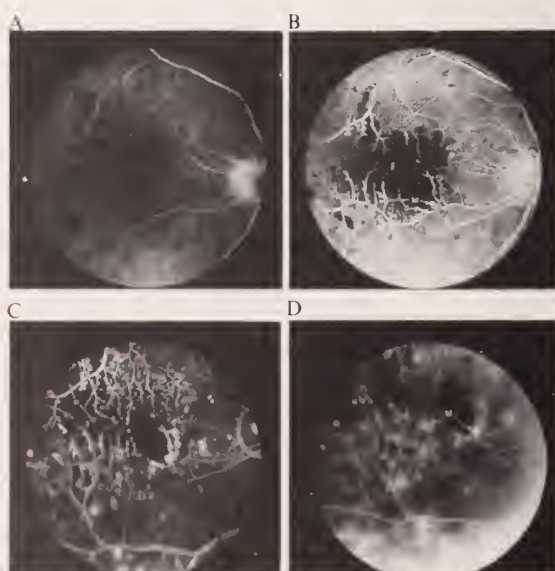
*Figure 2*—Normal fluorescein angiogram. A indicates the retinal arterial phase demonstrating previous filling of the choriocapillaries (c) in a mottled pattern; B shows the venous phase; and C, the arteriovenous phase.

Non-proliferative diabetic retinopathy comprises background diabetic retinopathy and consists of microaneurysms, hard (waxy) and soft (cotton-wool) exudates, intraretinal hemorrhages, and venous dilatation. The capillary bed is affected primarily on the venous side and is responsible for the demonstrable ophthalmoscopic and angiographic findings. The following cases exemplify the various types of diabetic retinopathy.

### Non-Proliferative Diabetic Retinopathy

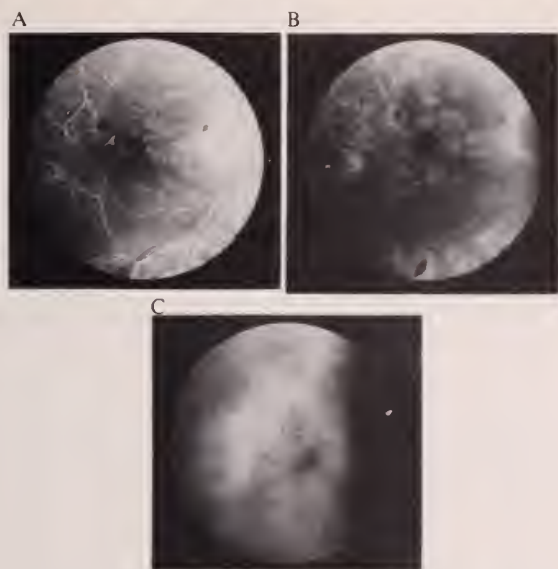
Figure 3-A shows the arterial phase in a patient with non-proliferative retinopathy. No gross abnormalities are seen in the arterioles. Some microvasculopathy including microaneurysms is noted in the arteriovenous phase (3-B). Solid evidence of profound capillary abnormalities and areas of capillary non-perfusion (N) or capillary drop-out are seen in figure 3-C. The marked increase in capillary permeability with leakage of dye (M) is well demonstrated later in the series Figure 3-D.

The leading cause of visual impairment in the non-proliferative stage is macular edema secondary to increased capillary permeability. In



*Figure 3*—Non-proliferative diabetic retinopathy. A shows the arterial phase without any gross changes; B, the A-V phase, demonstrates multiple microaneurysms (M); capillary non-perfusion (N) is noted in C; increased capillary permeability with leakage of dye from the microaneurysms (M) is widespread in the late phase, D.





*Figure 4*—The progression from the A-V phase A through C demonstrates severe capillary deterioration with late staining of the intraretinal (macular) edema in diabetes.



*Figures 5*—Preproliferative stage of diabetic retinopathy. In the arterial phase, A, no changes are noted. The dark beaded vessel (V) is a vein which fills in B demonstrating severe disease. To the left is microangiopathy suggestive of early neovascularization (N). C shows the increased vascular permeability as evidenced by blurred outlines of small vessels.

Figures 4-A through 4-C the progression of the leakage of dye which leads to profound staining of the macular resembling a cystic pattern is clearly demonstrated.

The late stages of non-proliferative diabetic retinopathy are seen in figure 5. Note that in (A), the arterial phase, no abnormalities are visible. The dark vessel (V) is a vein and is not yet filled with dye. However, the beaded nature of its outline is visible. Late in the venous phase (B) the marked abnormal capillary bed is noted as is the beading of the vein. (B) also shows very early neovascular changes, which may herald the onset of the proliferation stage. As arterial emptying occurs the marked microvasculopathy becomes more evident (C).

### Proliferative Diabetic Retinopathy

The retina enters the proliferative phase of diabetic retinopathy when frank neovascularization is noted by ophthalmoscopy. Figure 6-A shows a patch of retinal neovascularization early in the arteriovenous phase. This abnormal vasculature is markedly permeable to the dye, leaks profusely and obliterates the margins of

the capillaries of which it is comprised (figures 6-B, C). Figures 7-A, B, C illustrates retinitis proliferans emanating from the optic nerve.

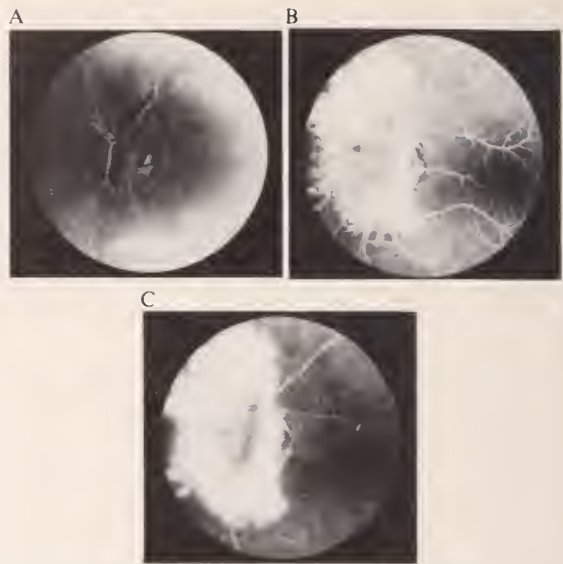
### Primary Retinal and Choroidal Disease

Previous occlusions of retinal vein branches also are associated with capillary abnormalities, macular edema and sometimes neovascularization. Figure 8 shows the former two characteristics. The dye leaks out of the vessels (A, B, C) and pools above the macula in a cystoid pattern (D). This condition can cause reduced vision by producing macular edema or neovascularization with subsequent hemorrhage.

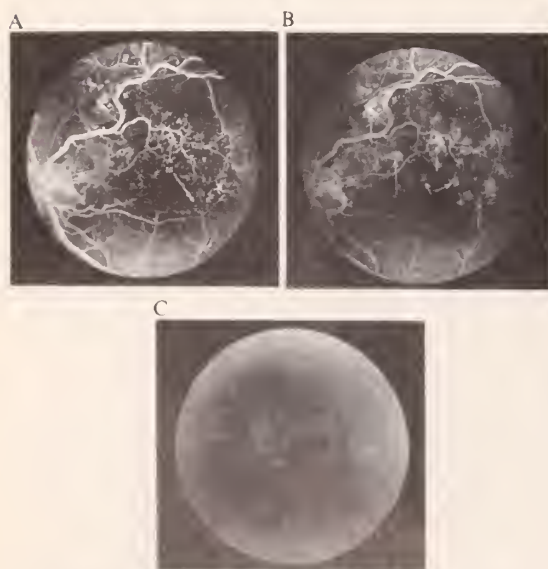
*Central serous choroidopathy* is a condition affecting adults, in the 20 to 50 year age group. It is characterized by distortion of the vision and reduced visual acuity. The cause of the symptoms is subretinal macular edema due to choroidal leakage. It is associated with anxiety and tension and usually resolves spontaneously; laser therapy is occasionally used. The characteristic angiographic findings are seen in figure 9. Three spots of hyperfluorescence or increased concentration of dye begin to present in the



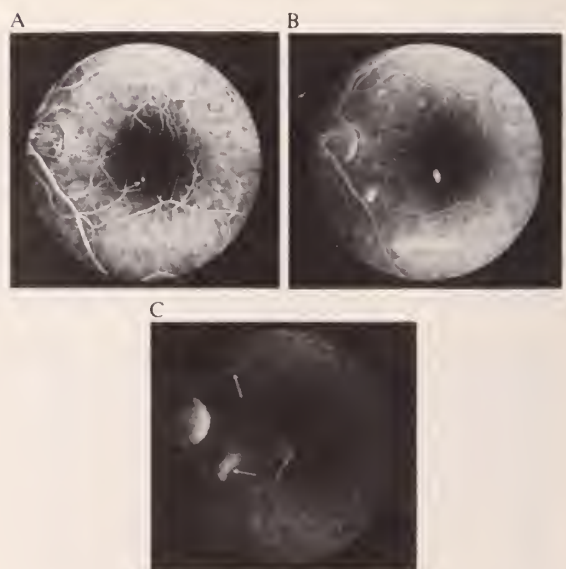
*Figure 6—Proliferative diabetic retinopathy. A large patch of neovascularization (arrows) is seen in A. B and C demonstrate profound leakage of these new vessels due to marked permeability.*



*Figure 7—Retinitis proliferans on the nerve head. The arterial phase, A shows no gross abnormalities; B, the A-V phase, outlines the proliferative tissue with late staining of the surrounding vitreous seen in C.*



*Figure 8—Old retinal vein branch occlusion. In A capillary abnormalities (A) and microaneurysms (M) are seen along the distribution of the previously occluded superotemporal vein. There is leakage seen from these changes (arrows) in B; a cystoid area (C) of edema is present late in the study, C.*



*Figure 9—Central serous choroidopathy. Areas of hyperfluorescence are noted in A, (arrows). B demonstrates blurring of the margins of the lower two spots indicating leakage into the subretinal space. In C this change is more marked. The upper retinal pigment epithelial detachment shows no activity in this eye.*

arteriovenous phase and become quite prominent as the study progresses. Their points of leakage are actually small detachments of the retinal pigment epithelium. The very late phases (C, D) show marked blurring of the dye with "smoke stacking," a condition in which the dye is passing through two retinal pigment epithelial detachments into the subretinal space. The upper retinal pigment epithelial detachment shows no late blurring (D) and therefore is not leaking.

*Choroidal tumors* such as malignant melanomas (figure 10) are quite dramatically demonstrated, however, they cannot be differentiated angiographically from hemangiomas and metastatic disease.

*Cystoid macular edema* after cataract extraction is seen in figure 11. Note that in the early phase there is no leakage of dye (A). In the later phase, however, a small amount of dye is noticeable (B). Very late in the series a prominent stellate pattern of dye, which is classical for this condition, is present (C). This indicates marked retinal capillary permeability the cause of which is unknown.

### Indications for Fluorescein Angiography

Fluorescein angiography is useful in a great many other chorioretinal abnormalities, including macular degenerations, vasculopathies, hemoglobinopathies, and in inflammatory conditions. Indications for this study are as follows:

1. Unexplained changes in vision
2. Evaluation of general retinal vascular status
3. Changes in macular and perimacular areas
4. Ophthalmoscopic evidence of macular edema
5. Pre-retinal hemorrhagic activity
6. Suspected retinal neovascularization
7. Vitreous hemorrhage (after clearing)

Acknowledgement is made to Richard Press, Ophthalmic Photographer of the Eye Institute of New Jersey for technical assistance.

### References

1. Novotny HR and Alvis DL: Method of photographing fluorescence in circulating blood in human retina. *Circulation* 24:82, 1961.
2. Wessing A: *Fluorescein Angiography of the Retina*. St. Louis, Mosby, 1969, p. 15.

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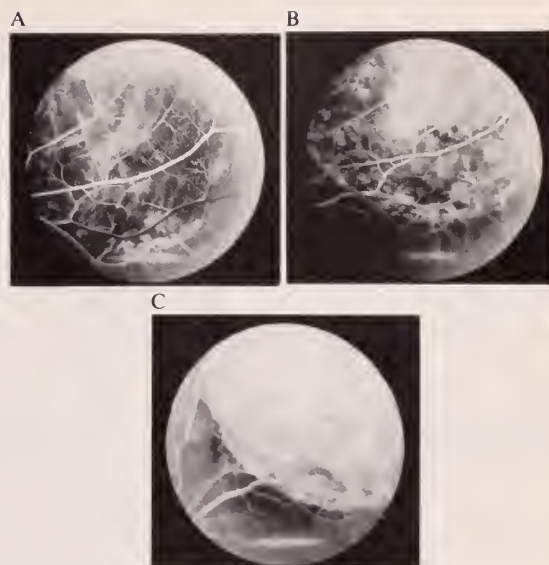


Figure 10—Malignant melanoma. Choroidal filling is seen in A, (arrows). This becomes more widespread and concentrated in B; the whole tumor stains heavily in C.

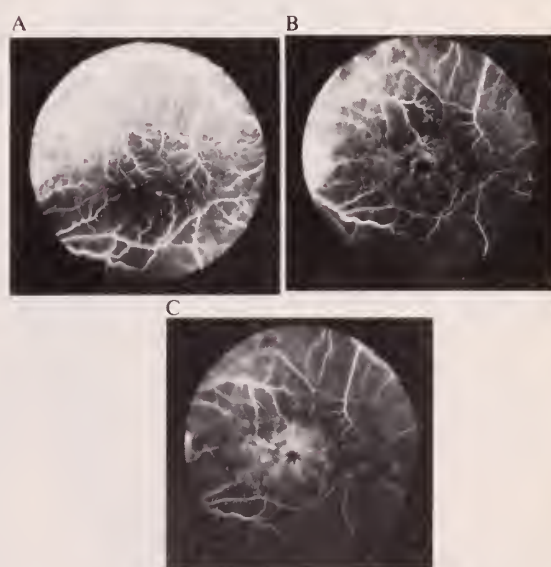


Figure 11—Cystoid macular edema. The late A-V phase shows very early barely visible hyperfluorescence around the fovea, A (arrows). B, shows a concentric filling pattern. The marked retinal leakage into a stellate pattern around the fovea (C) is characteristic of the Irvine-Gass syndrome.



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**Cardilate (erythrityl tetranitrate)**

**INDICATIONS** For the prophylaxis and long-term treatment of patients with frequent or recurrent anginal pain and reduced exercise tolerance associated with angina pectoris rather than for the treatment of the acute attack of angina pectoris since its onset is somewhat slower than that of nitroglycerin.

**PRECAUTIONS** As with other effective nitrites, some fall in blood pressure may occur with large doses.

Caution should be observed in administering drug to patients with a history of recent cerebral hemorrhage because of the vasodilation which occurs in the area. Although therapy permits more normal activity, the patient should not be allowed to misinterpret freedom from anginal attacks as a signal to drop all restrictions.

**SIDE EFFECTS** No serious side effects have been reported. In sublingual therapy, a tingling sensation (like that of nitroglycerin) may sometimes be noted at the point of tablet contact with the mucous membrane. If objectionable, this may be mitigated by placing the tablet in the buccal pouch. As with nitroglycerin or other effective nitrites, temporary vascular headache may occur during the first few days of therapy. This can be controlled by temporary dosage reduction in order to allow adjustment of the cerebral hemodynamics to the initial marked cerebral vasodilation. These headaches usually disappear within one week of continuous therapy but may be minimized by the administration of analgesics.

Mild gastrointestinal disturbances occur occasionally with larger doses and may be controlled by reducing the dose temporarily.

**HOW SUPPLIED** 10 mg chewable scored tablets in bottles of 100. Also 5, 10 and 15 mg oral sublingual scored tablets in bottles of 100. 10 mg oral sublingual scored tablets also supplied in bottles of 1,000.

Also available: Cardilate\* P brand Erythrityl Tetranitrate with Phenobarbital\* Tablets. Scored.

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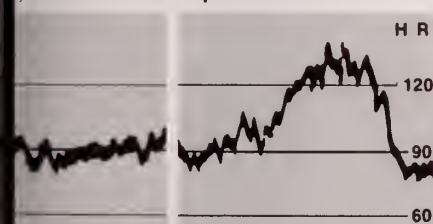
# Sex and the heart patient:

A film every doctor should see.

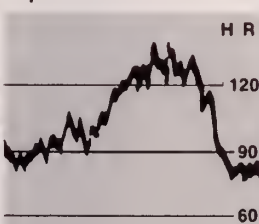
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Representations below of actual ECG readings of an attorney, post MI, illustrate the point:



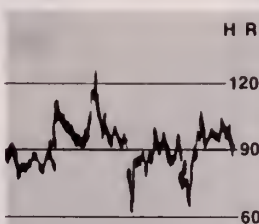
A Working in office (about 90 beats/min)



B Confrontation in judge's chamber (about 125 beats/min)



C Pre-orgasm sex activity (about 90 beats/min)



D Peaks at orgasm (120 beats/min)



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*The increased incidence of infection in splenectomized patients is examined. The role of the spleen in resisting infection is reviewed with specific attention to antigen clearance, antibody production, properdin deficiency and tuftsin. Sepsis in splenectomized patients is caused predominantly by the pneumococcus, though other significant pathogens include the meningococcus, E. coli, H. influenzae and staphylococcus. Several methods of managing splenectomized patients are presented with discussion of selected advantages and disadvantages inherent to each method. Anti-pneumococcal vaccines were considered promising, however, at the present time, oral penicillin prophylaxis is considered the superior method of preventing overwhelming postsplenectomy sepsis.*

## Prevention of Overwhelming Sepsis in the Asplenic Patient

**Robert Palinkas, M.D. and  
Leon Smith, M.D., Newark\***

The role of the spleen in the defense against infection was first considered by Morris and Bullock in 1919.<sup>1</sup> This concept received little attention until 1952 when King and Shumacher reported fulminant sepsis in five infants.<sup>2</sup> Since then many reports have established the higher incidence of infection in patients having impaired or absent splenic function.<sup>3</sup>

### Incidence

The entity of overwhelming postsplenectomy infection is characterized by abrupt onset, unusual exuberance of bacterial growth, high incidence of disseminated intravascular coagulation, death within hours of onset, and a mortality rate as high as 80 percent.<sup>4</sup>

In a review of the subject Singer concluded that the overall incidence of sepsis in asplenic persons was 4.25 percent and the mortality was 2.52 percent.<sup>5</sup> Another study found the mortality due to sepsis in asplenic persons is at least 200 times the incidence of fatal sepsis in the population at large.<sup>6</sup> The underlying cause of the asplenic state had a great effect on the incidence of fatal sepsis.<sup>7</sup> When the spleen is removed for splenic trauma the incidence of fatal sepsis is 14 times greater than in persons with a spleen.<sup>8</sup> In patients who were splenectomized for idiopathic thrombocytopenic purpura the risk of fatal sepsis is 37 times greater than in normal populations; for those patients

splenectomized for hereditary spherocytosis it is 45 times greater than expected.<sup>9</sup> In the majority of asplenic persons serious infections occur within 24 months of splenectomy.<sup>10</sup> The occurrence of later infections, however, is well documented.<sup>11</sup>

### Pathogenesis and Etiology

Recognition of the infective risk of splenectomy has spurred investigation into the specific mechanisms by which the spleen protects against infection. Several studies have shown that one of the most important mechanisms involved is the clearance of particulate antigens from the blood. This mechanism is of greatest importance when the concentration of antibodies to the infecting agent is low.<sup>12</sup>

Removal of the spleen has little effect on the net functional potential of antibody production.<sup>13</sup> There are, however, several studies which suggest that serum IgM and possibly IgA are lower in asplenic states.<sup>14</sup> Another immunologic role of the spleen may be the production of properdin (a part of the alternate pathway to the complement system), which has been shown to be deficient in asplenic patients.<sup>15</sup> Additionally, asplenic persons have been shown to be deficient in tuftsin, a tetrapeptide derived from leukocyte-bound IgG which stimulates phagocytosis.<sup>16</sup>

\*Dr. Smith is Director, Department of Medicine, St. Michael's Medical Center, Newark. When this paper was prepared Dr. Palinkas was a fourth year medical student at CMDNJ, New Jersey Medical School; he currently is a resident in internal medicine at Martland Hospital Unit, CMDNJ, Newark.

Cellular immunity and virus-induced interferon production appears to be unimpaired in the asplenic patient.<sup>17 18</sup> One study, however, demonstrated a significant increase in the incidence of varicella-zoster infections in a group of Hodgkin's disease and non-Hodgkin's lymphoma patients under chemotherapy who had undergone splenectomy versus a similar group of non-splenectomized patients.<sup>19</sup>

Sepsis in splenectomized individuals is predominantly caused by the *pneumococcus* (over 50%).<sup>20</sup> Other organisms seen in asplenic sepsis are the *meningococcus* (12%), *E. coli* (11%), *Hemophilus influenzae* (8%), *staphylococcus* (8%), and *streptococcus species* (7%).<sup>21</sup> Other types of infection also have occurred at higher incidence in asplenic patients, such as malaria and babesiosis.<sup>22 23</sup>

### Prevention

Recognition of the role of the spleen in the prevention of fatal infections has caused reassessment of the indications for splenectomy.<sup>24</sup> It has been suggested that splenectomy be delayed, if possible, for infants and children for as long as possible.<sup>25</sup> Some investigators have reported that partial splenectomy or conservative management of rupture of the spleen following blunt abdominal trauma is feasible in selected cases.<sup>26 27</sup>

Other investigators believe that autotransplantation of splenic tissue may provide protection against overwhelming sepsis in cases where such a procedure is not contraindicated.<sup>26</sup> It is known that autotransplantation of splenic tissue results in reorganization of the splenic tissue into structures that are indistinguishable from the original spleen. These reorganized splenic implants performed erythrophagocytosis and have been shown to protect experimental animals against *Bartonella muris* infections.<sup>29</sup>

One of the most promising projects in the prevention of pneumococcal infection is the development of anti-pneumococcal vaccines. It has been estimated that more than 80 percent of pneumococcal pneumonias in otherwise normal

patients are "vaccine types."<sup>30</sup> That is, the specific antigenic type of the pneumococcal isolates represented strains for which an effective vaccine presently exists. Unfortunately, the multivalent vaccine necessary to confer protection against a majority of pneumococci is not available for use as yet.

There are several reasons why the anti-pneumococcal vaccines may not prove to be as useful in asplenic patients as may be expected. The incidence of "vaccine types" in pneumococcal bacteremias has been estimated to be only 60 percent.<sup>31</sup> Hence, up to 40 percent of the pneumococcal bacteremias one would see in the asplenic patient may not be as yet "vaccine types." There is further evidence that immunization done after splenectomy may not be effective, especially in the period immediately following splenectomy.<sup>32</sup> In addition, it is known that the incidence of various antigenic types in pneumococcal infections is changing.<sup>33</sup> Therefore immunization protection may vary as new patterns emerge.

The most reasonable means of protecting the asplenic patient at this time is the use of prophylactic penicillin. There is much experience with penicillin prophylaxis for rheumatic fever,<sup>34</sup> and one study of prophylactic penicillin for splenectomized patients with Hodgkin's disease suggested that it afforded a reasonable degree of protection.<sup>35</sup>

Recommendations about the duration and dosage of penicillin prophylaxis vary, however, most recent opinions recommend at least two years of sustained penicillin prophylaxis (250 mg of penicillin V twice daily).<sup>36 37</sup> Since overwhelming infection also has been recognized as a later complication of splenectomy, antibiotic prophylaxis may be indicated for an indefinite period.<sup>38</sup>

### References

1. Morris DH and Bulloc FD: The importance of the spleen in resistance to infection. *Ann Surg* 70:513, 1919.
2. King H and Shumacher HB: Splenic studies. 1. Susceptibility to infection after splenectomy performed in infancy. *Ann Surg* 136:239, 1952.

3. Dickerman JD: Bacterial infection and the asplenic host: A review. *J Trauma* 16:662-668, 1976.
4. Lucas RV and Krivit W: Overwhelming infection in children following splenectomy. *J Pediatr* 57:185, 1960.
5. Singer DB: Postsplenectomy sepsis. In Rosenberg HS and Bolande RP (eds): *Perspectives in Pediatric Pathology*, Vol. 1. Chicago, Year Book Medical Publishers, 1973, pp 285-311.
6. Dauer CC, Korn RF, and Schuman LM: *Infectious Diseases*. Cambridge, Harvard University Press, 1968, pp 134-139.
7. Dickerman JD: Bacterial infection in the asplenic host: A review. *J Trauma* 16:662-668, 1976.
8. *ibid*
9. *ibid*
10. *ibid*
11. Case Records of the Massachusetts General Hospital. *N Engl J Med* 293:547, 1975.
12. Bogart D, Biggar WD and Good RA: Impaired intravascular clearing of pneumococcus type-3 following splenectomy. *J Reticuloendothelial Soc* 11:77-87, 1972.
13. Likhite VV: Immunological impairment and susceptibility to infection after splenectomy. *JAMA* 236:1376-7, 1976.
14. Hancock BW, Lesley B, Ward AM and Richmond J: Changes in immune status in patients undergoing splenectomy for the staging of Hodgkin's disease. *Br Med Jour* 1:313-315, 1976.
15. Carlisle HN and Saslaw S: Properdin levels in splenectomized persons. *Proc Soc Exp Biol Med* 102:150, 1959.
16. Constantopoulos A, Najjar VA: Tuftsin, a natural and general phagocytosis-stimulating peptide affecting macrophages and polymorphonuclear leukocytes. *Cytobios* 6:97-100, 1972.
17. Wegener, DJT, Geestmen E, Borgonjen A, and Haanen C: The influence of splenectomy on cellular immunologic parameters in Hodgkin's disease. *Cancer* 37:2212-2219, 1976.
18. Ito y, Kunii A and Nagata I: Effects of splenectomy on production of endotoxin type interferon in mice. *Virology* 44:638-41, 1971.
19. Monfardini J, Bajetta E, Arnold CA, Kenda R and Bonnadonna G: Herpes Zoster-Varicella infection in malignant lymphomas. Influence of splenectomy and intensive treatment. *Europ J Cancer* 11:51-57, 1975.
20. Dickerman JD: Bacterial infection in the asplenic host: A review. *J Trauma* 16:662-668, 1976.
21. Singer DB: Postsplenectomy sepsis. In Rosenberg HS and Bolande RP (eds): *Perspectives in Pediatric Pathology*, Vol. 1. Chicago, Year Book Medical Publishers, 1973, pp 285-311.
22. *ibid*
23. *ibid*
24. Strauch GO: Should we attempt to salvage the injured spleen? *Connecticut Med* 39:533-535, 1975.
25. Editorial: Infective hazards of splenectomy. *Lancet* 1 7970:1167-8, 1976.
26. Mishalony H: Repair of the ruptured spleen. *J Pediatr Surg* 9:175, 1974.
27. Douglas GJ and Simpson JS: The conservative management of splenic trauma. *J Pediatr Surg* 6:565-570, 1971.
28. Likhite VV: Immunological impairment and susceptibility to infection after splenectomy. *JAMA* 236:1376-7, 1976.
29. Crosby WH, and Benjamin NR: Frozen spleen reimplanted and challenged with *Bartonella*. *Am J Pathol* 39:119-127, 1961.
30. Kaiser AB, Schaffner W: Prospectus: The prevention of bacteremic pneumococcal pneumonia. *JAMA* 230:404-408, 1974.
31. *ibid*
32. Leung LE, Szal GJ, and Drachman RH: Increased susceptibility of splenectomized rats to infection with *Diplococcus pneumoniae*. *J Infect Diseases* 126:507-513, 1972.
33. Austrian R: Current status of bacterial pneumonia with especial reference to pneumococcal infection. *J Clin Pathol* 21 (Suppl 2):93-97, 1968.
34. Markowitz M and Kuttner AG: *Rheumatic Fever: Diagnosis, Management, and Prevention*. Philadelphia, Saunders, 1965, pp 129-135.
35. Lanzowsky P, Karayalcin G, Shande A, et al: Complications of laparotomy and splenectomy in the staging of Hodgkin's disease in children. *Pediatr Res* 9:389, 1975.
36. Walker W: Splenectomy in childhood: A review in England and Wales. *Br J Surg* 63:36-43, 1976.
37. Editorial: Infective hazards of splenectomy. *Lancet* 1 7970:1167-8, 1976.
38. Dickerman JD: Bacterial infection in the asplenic host: A review. *J Trauma* 16:662-668, 1976.

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*One hundred eighty-one patients underwent a second trimester abortion by intra-amniotic hypertonic saline or prostaglandin F<sub>2</sub> alpha. These methods were aided by Laminaria tent insertion and Pitocin® stimulation. Major complications were noted with the saline method. Prostaglandin proved the most effective and least risky. Concurrent intra-amniotic calcium gluconate did not add to the efficiency of the prostaglandin.*

## Medical Termination of Midtrimester Pregnancy in a Community Hospital

**Paul E. Stroup, M.D., Camden\***

There are numerous methods of terminating a second trimester pregnancy. As long as this is a feature of obstetric practice, the methodology requires constant evaluation to select the most effective and least complicated procedure available. The following cases are presented with this view in mind.

### Material and Methods

Over four years one hundred eighty-three patients were admitted to The Cooper Medical Center for midtrimester abortion. The ages ranged from twelve to forty-three with 38 percent eighteen or younger (Table 1). The gestational age varied from fourteen to twenty weeks with 64 percent being over sixteen weeks. The patients were divided into four groups according to the method of abortion employed: (1) saline, (2) saline with Laminaria tent (L.T.), (3) prostaglandin (PGF<sub>2</sub>α with Laminaria tent, and (4) prostaglandin with calcium gluconate and Laminaria tent (Table 2).

**Table 1**  
*Mid Trimester Terminations*

Age (years)	Number
12-17	70
18-43	113
Admission Status --	
Private	80
Non-Private	103
Gestational Age -- Weeks	
14-16	67
17-20	116

**Table 2**  
*Mid Trimester Abortions*

Method	Result	
	Number of Patients Success	Failure
Saline	23	1
Saline (L. T.)	37	0
Prostin <sup>a</sup>	99	1
Prostin <sup>a</sup> -Calcium	22	0

<sup>a</sup>Prostin (Upjohn Co.)

### Technique

After routine blood and urine studies were obtained and the bladder emptied, each patient was admitted to the labor suite. The abdomen was prepared with an antiseptic solution and draped with sterile towels. A point in the midline, about two inches below the uterine fundus, was injected with 10cc of a two percent lidocaine solution. A 17G Tuohy needle was inserted into the amniotic cavity. When hypertonic saline was to be used, the amniotic fluid was allowed to drain until the flow ebbed. Then 200 to 300cc of a 23 percent sodium chloride solution was infused, followed by a physiologic saline flush of the needle track. During the procedure an intravenous infusion of 1000cc of five percent dextrose in water was administered. If the postinfusion status remained normal, the patient was returned to the floor.

When prostaglandin was to be used, 40mg alone or combined with one gram of calcium gluconate was infused into the amniotic cavity. All of these patients and most of the patients treated with saline had a Laminaria tent in-

\*Dr. Stroup is attending obstetrician, The Cooper Medical Center, Camden.

sented. Prior to insertion a Zephiran® chloride (1-2000) or Betadine® douche was used. In addition, patients treated with PGF<sub>2</sub>α received prophylactic Lomotil<sup>®</sup>,<sup>b</sup> 2.5mg every four hours, and Emete-con<sup>®</sup>,<sup>c</sup> 50mg intramuscularly every hour for two hours and then as needed.

The patients were returned to the labor suite with the onset of regular contractions. If effective contractions didn't start by the following morning an intravenous Pitocin® infusion (50u/1000cc Ringer's lactate solution) was started. Then the Laminaria tent was removed and the membranes ruptured.

## Results

Sixty-one patients had hypertonic saline infusion. Thirty-seven had a Laminaria tent inserted; 24 did not.

**Saline**—One of the 24 represents a method failure. The abortion was completed by surgical evacuation two days after the saline infusion. Of the remaining 23 the majority (16) expelled the fetus within 24 to 36 hours of intra-amniotic infusion (Table 3). Intravenous Pitocin® was required for expulsion in 69 percent. Thirty-nine percent of patients needed meperidine hydrochloride<sup>d</sup> during the abortion, and 17 percent had gastrointestinal complaints (Table 4). The most common complication was a temperature of 100° or more recorded after the intra-amniotic infusion (Table 4). This included all the patients with endometritis and most of those requiring a dilatation and evacuation (D and E) or manual removal of the placenta.

The second most common complication was concerned with management of the placenta. The four D and E operations were postexpulsion and included one done seven days after discharge from the hospital. In those with delayed placental expulsion, i.e., more than one hour after fetal expulsion, the average time was two and a half hours. The patient with hypernatremia became comatose, had convulsions and intravascular hemolysis, but responded to treatment and was discharged after three days.

<sup>b</sup>Searle & Co.

<sup>c</sup>Roerig (Pfizer Pharmaceuticals)

<sup>d</sup>Demerol® (Winthrop)

Table 3  
Saline  
Fetal Expulsion Time

		Non-parous (12)				
Hours		12	18	24-26	30-36	44
Number		1	1	3	6	1

		Parous (11)				
Hours		16	18-20	25-27	30-36	47
Number		1	2	4	3	1

Pitocin® Required 69%  
Duration of Infusion

		Non-parous (8)					Parous (8)		
Hours		.5	2.5	7-12	21	31	1.5	2-7.5	20
Number		1	1	4	1	1	1	6	1

Table 4  
Saline — Side-Effects

	No Pitocin®	Pitocin®
Pain	3	6
G. I. Symptoms	2	2

Complications

Failures	1
D & E	4 (1)
Placenta	
Delayed expulsion	3
Manual removal	3
Temp. 100° or >	11
Endometritis	2
Hypernatremia	1

**Saline and Laminaria tent**—Of the 37 patients treated with saline and a Laminaria tent there were no method failures. In the majority (31) the fetus was expelled in 10 to 29 hours after intra-amniotic infusion (Table 5). Intravenous Pitocin® was required for expulsion in 51 percent. Sixty-two percent of the patients needed meperidine hydrochloride<sup>d</sup> during the abortion; 13 percent had gastrointestinal complaints (Table 6). A temperature of 100° or more occurred in 21 percent of the patients (Table 6). Of the nine postexpulsion D and E's, one was performed 21 and one 28 days after discharge from the hospital. The patient with hypofibrinogenemia had moderate bleeding complicating a partially separated placenta. During surgical



evacuation persistent uterine atony and hemorrhage were noted. A fibrinogen level at that time was reported as 90mg/dl. The atony gradually responded to massage and intravenous Pitocin®.

Table 5  
Saline and Laminaria Tent  
Fetal Expulsion Time

		Non-parous (23)				
Hours	8	10-17	18-24	26-29	30-36	
Number	1	5	10	4	3	

	Parous (14)				
Hours	9	10-17	19-25	27-29	30
Number	1	4	4	4	1

Pitocin® Required (51%)  
Duration of Infusion

		Non-parous (12)				Parous (7)		
Hours	.5	1-4	9	12	3	4-9	19	
Number	2	7	2	1	1	5	1	

Table 6  
Saline and Laminaria Tent -- Side Effects

	No Pitocin®	Pitocin®
Pain	17	6
G. I. Symptoms	5	0

Complications

Failures	0
D & E	9 (2)
Placenta	
Delayed expulsion	1
Manual removal	1
Temp. 100° or >	8
Endometritis	1
Hypofibrinogenemia	1

**Prostaglandin**—One hundred twenty-two patients had a prostaglandin infusion and Laminaria tent insertion. Twenty-two also had intra-amniotic calcium gluconate. Of the 100 patients without calcium gluconate one represented a method failure. The abortion was completed by surgical evacuation 28 hours after PGF<sub>2α</sub> infusion. Of the 99 spontaneously expelling the fetus this occurred in the majority (82) within 8 to 25 hours postinfusion (Table 7). Intra-

venous Pitocin® was required for expulsion in 40 percent. Sixty-six percent of the patients needed meperidine hydrochloride<sup>d</sup> during the abortion, and 16 percent had gastrointestinal complaints (Table 8). A temperature of 100° or more occurred in 9 percent of the patients (Table 8). Thirty-four percent had a problem with management of the placenta, but no patient had to be readmitted for a D and E. Of the four patients who needed a second injection one procedure was terminated because of a persistently bloody tap but it was performed successfully the following day. In the other three the abdominal approach failed because of obesity and small uterine size. When this occurred, the PGF<sub>2α</sub> was injected into the uterus through the anterior vaginal wall above the level of the internal os. The hypersensitivity reactions both occurred within one hour of infusion. In one the symptoms were shivering, diarrhea, and an immediate increase in the temperature to 102° (in the patient with the abdominal injection). In the other the temperature rose suddenly to 101°, and the blood pressure increased to 184/110 from 150/90 (the patient with the vaginal injection).

Table 7  
Prostin  
Fetal Expulsion Time

	Non-parous (54)				
Hours	7	9-16	18-25	26-32	34
Number	2	22	22	7	1

	Parous (45)				
Hours	5	8-16	18-25	26-29	54
Number	1	21	17	5	1

Pitocin® Required (40%)  
Duration of Infusion

		Non-parous (22)				Parous (18)			
Hours	.5	.7-3	5-9	10	1	2-7	14	29	
Number	1	13	7	1	3	12	2	1	

**Prostaglandin-Calcium**—Twenty-two patients received an intra-amniotic PGF<sub>2α</sub> and calcium gluconate infusion with a Laminaria tent. There were no failures. One hundred percent expelled the fetus within 25 hours (Table 9). Intravenous

Pitocin® was required for expulsion in 31 percent. Seventy-seven percent of the patients needed meperidine hydrochloride<sup>d</sup> during the abortion, and 27 percent had gastrointestinal complaints (Table 10). There was no morbidity. Although eight patients had trouble with the management of the placenta (Table 10), no D and E's were required. The patient with uterine hemorrhage had a partial placental separation with uterine retention of the blood. This responded to manual removal of the placenta.

Table 8 Prostin <sup>a</sup> — Side Effects		
	No Pitocin®	Pitocin®
Pain	58	7
G. I.	16	0
Complications		
Failures		1
D & E		15
Placenta		
Delayed expulsion		7
Manual removal		12
Temp. 100° or >		9
Endometritis		1
Hypersensitivity		2
Second injection		4

Table 9 Prostin <sup>a</sup> — Colcium Fetal Expulsion Time			
Non-parous (15)		Parous (7)	
Hours	13-17   18-25	10-14   24-25	
Number	7   8	4   3	
Pitocin® Required (31%)			
Duration of Infusion			
Non-parous (4)		Parous (3)	
Hours	1-2	2-3	
Number	4	3	

In none of the four categories did parity influence the expulsion time or the need for Pitocin®. Comparison of the efficacy in producing fetal expulsion was accomplished by eliminating the extremes and plotting the values of the majority (Figure 1). The PGF<sub>2α</sub> groups dem-

onstrated a superiority over the saline groups by earlier expulsion times; however, there was no apparent difference between the two PGF<sub>2α</sub> groups.

Pitocin® was required for fetal expulsion in 50 percent or more in the saline groups and less than 50 percent in the PGF<sub>2α</sub> groups (Table 11). There was no well-defined difference between the saline and PGF<sub>2α</sub> groups in the development of gastrointestinal symptoms or the need for analgesics during the abortion.

Morbidity was appreciably higher in the saline groups. Although there appears to be a difference between the saline and PGF<sub>2α</sub> groups concerning placental management, this disappears when the D and E's are combined with the delayed placental expulsion-manual removal group.

### Comments

Although intra-amniotic hypertonic saline is effective in producing midtrimester abortion, serious complications such as acute disseminated intravascular coagulation and hypernatremia make this procedure obsolete.

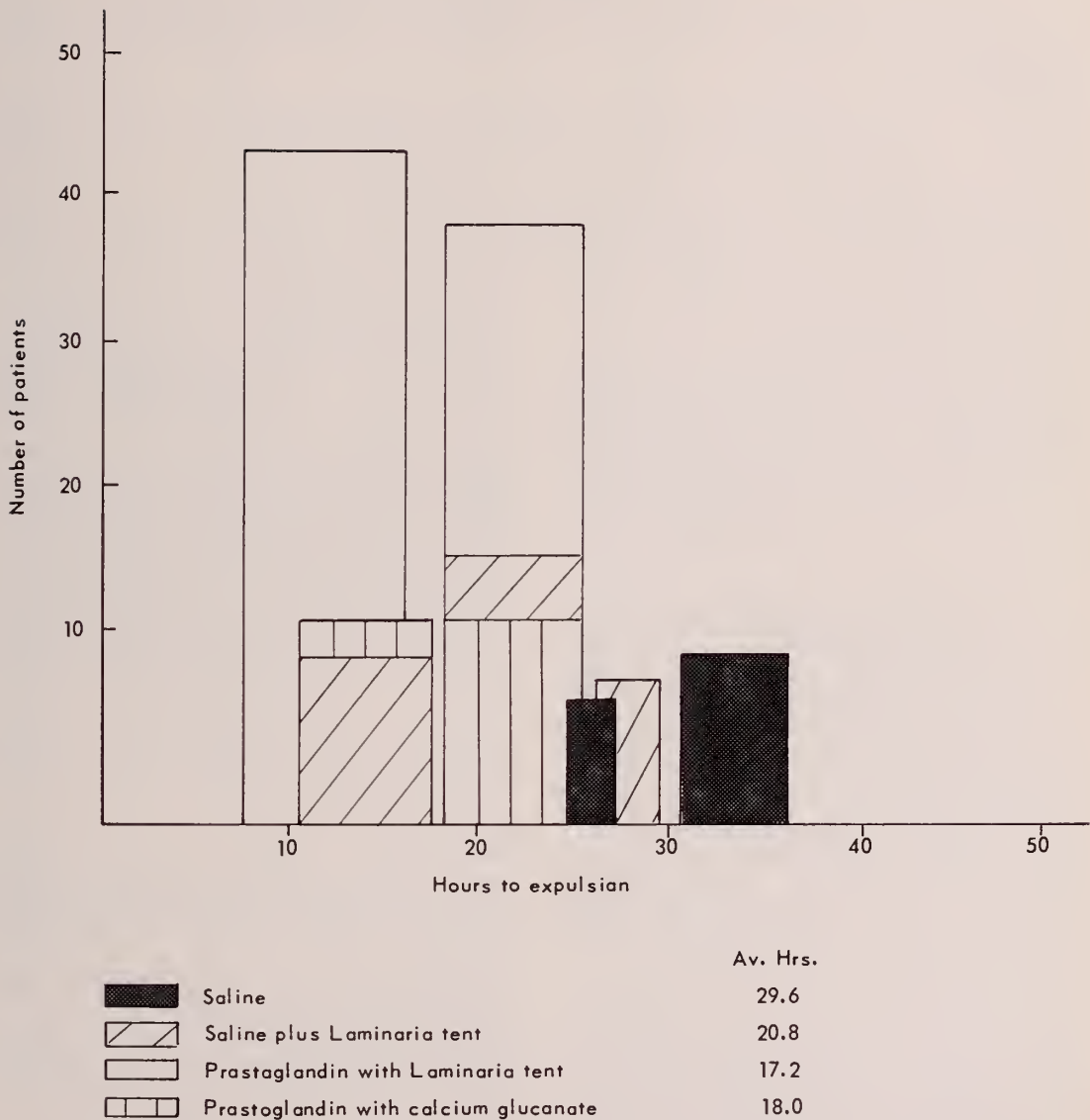
A single intra-amniotic injection of 40 mg of prostaglandin can be expected to produce spontaneous (unstimulated) fetal expulsion in about 60 percent of midtrimester pregnancies. In the remainder the uterus is converted into an oxytocin-sensitive organ. Although this conversion has been noted as early as 90 minutes after prostaglandin<sup>1</sup>, the early use of a concen-

Table 10 Prostin <sup>a</sup> — Colcium — Side Effects		
	No Pitocin®	Pitocin®
Pain	17	0
G. I.	6	0
Complications		
Placenta		
Delayed expulsion		2
Manual removal		6
Uterine hemorrhage		1

<sup>a</sup>Prostin (Upjohn Co.)

<sup>d</sup>Demerol® (Winthrop)

Figure 1  
Method Comparison -- Fetal Expulsion



trated intravenous oxytocin solution has not reduced the average infusion-abortion time.<sup>1,2</sup> When the Pitocin® was used as described in this study, the fetus was expelled in 50 percent within three hours of the start of the infusion. This technique avoids the prolonged use of an intravenous as described in other studies<sup>1,2</sup> and also reduces the possibility of water intoxication.

Although a recent study<sup>3</sup> using a combined intra-amniotic infusion of  $\text{PGF}_{2\alpha}$  and calcium

gluconate demonstrated a greatly reduced infusion to abortion time, the same procedure reported here failed to demonstrate such a result.

The use of a Laminaria tent in the abortion process does not seem to affect the morbidity and has eliminated the problem of spontaneous cervical laceration. In addition, when labor isn't induced by the prostaglandin, the overnight use of a Laminaria tent almost always produces cervical dilatation sufficient for artificial am-



Table 11  
Analysis (%)

	Saline	Saline (L. T.)	Prastin <sup>a</sup>	Prastin <sup>a</sup> - Calcium	Aver.
Pitacin® required	69	51	40	31	45
Demerol® required	39	62	66	77	63
G. I. symp.	17	13	16	27	17
Morbidity	48	22	9	0	15
D & E	17	24	15	0	15
Placenta*	26	5	19	36	19

\* Includes delayed expulsion and manual removal

niotomy. The latter seems to increase the effectiveness of the Pitocin.<sup>8</sup>

Intra-amniotic PGF<sub>2</sub> α, although an invasive technique, appears to be free of major complications; however, caution has been suggested with its use in patients with asthma, glaucoma, hypertension, epilepsy<sup>4</sup> and cardiovascular disease.<sup>5</sup>

Vomiting has been reported in half of the patients receiving prostaglandin.<sup>5</sup> This incidence is difficult to evaluate because many patients in the present study developed vomiting only after strong uterine contractions were present. This may reflect an individual's response to pain. Others developed vomiting only after receiving meperidine hydrochloride<sup>d</sup>. This is a known side effect of that medication. With the prophylactic use of medications as described in this study, gastrointestinal symptoms should be minor and occur in less than 20 percent.

The reduced morbidity noted in the PGF<sub>2</sub> α groups not only reflects the absence of the osmotic irritation of the hypertonic saline but also the reduced abortion time and more aggressive management of the retained placenta. The latter is seen in the absence of D and E's and the increased number of manual removals of the placenta in the PGF<sub>2</sub> α-calcium gluconate group.

### Summary

One hundred eighty-one patients between 14

and 20 weeks' gestation were aborted by an intra-amniotic hypertonic saline or prostaglandin infusion. Most of the patients had a Laminaria tent inserted. The PGF<sub>2</sub> α group demonstrated a shorter infusion-abortion time, average 17 hours. When calcium gluconate was added to the PGF<sub>2</sub> α, no potentiating effect was noted. In the PGF<sub>2</sub> α group intravenous Pitocin<sup>®</sup> was needed to complete the abortion procedure in 40 percent; side effects occurred in less than 20 percent and the most important complication, retained placenta, in 34 percent. At this time intra-amniotic PGF<sub>2</sub> α with a Laminaria tent is the most effective and least complicated method of terminating a second trimester pregnancy.

### References

1. Saldana LR, Schulman H, Yang W, *et al*: Midtrimester abortion by prostaglandin impact. *Obstet Gynecol* 44:579-585, 1974
2. Anderson G: Prostaglandin vs saline for midtrimester abortion. *Contemp Ob/Gyn* 4:91-95, 1974
3. Weinstein L, Droegemueller W and Greer B: The synergistic effect of calcium and prostaglandin F<sub>2</sub>α in second trimester abortion. *Obstet Gynecol* 48:469-471, 1976
4. Faden A, Golbus MS and Spire JP: Electroencephalographic changes following intra-amniotic prostaglandin F<sub>2</sub>α administration for therapeutic abortion. *Obstet Gynecol* 47:607-608, 1976
5. The Upjohn Company Monograph on Prostaglandin. The Upjohn Company, Kalamazoo, Michigan. Bulletin H-3243-9, November, 1973

<sup>a</sup>Prostin (Upjohn Co.)

<sup>d</sup>Demerol (Winthrop)

618 Benson Street, Camden

*The purpose of this communication is to illustrate a simplified surgical technique for the resuspension of the urethra and bladder neck to correct urinary stress incontinence in the female. The procedure prevents confusion of multiple sutures, and there is less tissue manipulation. The elevation of the urethra and the vesicourethral angle is excellent as was demonstrated in our patients' preoperative and postoperative metallic chain cystourethrogram. At present all of our patients treated with this technique are asymptomatic.*

## The Triple-Bite Single-Suture Technique for Correction of Urinary Stress Incontinence\*

**M. A. Pelosi, M.D., J. Apuzzio, M.D.,  
M. Frattarola, M.D., and  
T. S. Li, M.D., Newark**

During the past two decades many advances have been made in the diagnosis and treatment of female urinary stress incontinence. One of the most important contributions has been the precise definition of the anatomical abnormality in each patient so that the best operative technique can be determined.

### Type of Anatomical Defect

The basic factor involved in this condition is loss of tone in the fibromuscular support of the bladder base, bladder neck, and proximal urethra. This loss of support results in two types of anatomical defects. Type I is the complete or nearly complete loss of the posterior urethrovesical angle, but with the angle of inclination to the vertical of the urethral axis either normal or less than 45 degrees. Symptomatology, which ranges from mild to moderate incontinence, usually is managed by restoring the posterior urethrovesical angle by a vaginal repair (anterior colporrhaphy). Type II is the loss of the posterior vesico-urethral angle associated with a definitely abnormal angle of inclination of the urethral axis to the vertical; the latter is greater than 45 degrees. Patients having Type II defects often exhibit severe symptoms of incontinence as a result of a more profound weakening of the fibromuscular support; they usually require a retropubic urethropexy (Marshall-Marchetti-Krantz procedure) rather than an anterior colporrhaphy to effect a cure<sup>1</sup>.

Although new devices which determine the degree of rotation of the urethral axis are now being used<sup>2</sup>, the chain cystourethrogram is the most widely used diagnostic procedure to differentiate between the Type I and Type II anatomic configurations<sup>3</sup>.

### Corrective Operations

A variety of operations to correct stress incontinence in the female have been devised over the years. In an excellent review of the subject Green<sup>3</sup> summarized the modern approach for the surgical correction of this entity. The old clinical cliché, "do a vaginoplasty first, and if it fails, go above" is no longer acceptable. Type I stress incontinence is usually managed by an anterior colporrhaphy. Type II incontinence is best corrected by a retropubic urethropexy.

Marshall, Marchetti and Krantz<sup>4</sup> popularized the concept of elevating and fixing the urethra and bladder neck to the fibrous periosteum on the posterior surface of the symphysis pubis and the fascia of the anterior abdominal wall. The original technique, which may be found in any textbook of gynecological or urological surgery, has been essentially unchanged since the publication of their work in 1949.

It is the purpose of this communication to report a modification of the standard Marshall-Marchetti-Krantz procedure, "the triple bite single suture technique." We have found this

\*From the New Jersey Medical School, CMDNJ, Department of Obstetrics and Gynecology, Martland Hospital Unit.

modification to be easily performed, time saving, and as effective as the standard technique.

### Triple-Bite, Single-Suture Modification

The triple-bite, single-suture technique can be outlined as follows:

Preoperatively a number 18 Foley catheter with a five cc balloon is inserted into the bladder. We usually approach the space of Retzius by a Pfannenstiel incision, although we occasionally use a lower abdominal midline incision. The anterior rectus sheath is divided and the underlying rectus muscles are mobilized and separated in the midline in order to provide an adequate retropubic exposure which is necessary for dissection of the prevesical space and for the proper placement of the resuspended sutures. Any necessary intra-abdominal procedure is performed before the retropubic urethropexy. After the peritoneum is closed, the space of Retzius is dissected.

The bladder and the urethra are separated from the posterior surface of the symphysis pubis and the rectus muscles by blunt dissection. The bladder and the proximal two-thirds of the urethra should be mobilized completely and the paraurethral aspect of the anterior vaginal wall fully exposed and cleaned of fat and loose areolar tissue. The urethra and the bladder neck are identified by palpating the Foley catheter and the balloon. The surgeon retracts the fundus of the bladder and the adjacent peritoneum up and back to expose the proximal two-thirds of the urethra, the bladder neck, and the adjacent anterior vaginal wall. Simultaneously, an assistant inserts one or two fingers into the vagina and elevates the anterior vaginal wall and bladder neck to facilitate further exposure.

For the resuspension of the urethra and bladder neck we place a single suture, #1 chromic catgut, with a #4 Mayo needle on each side of the urethra. The first bite is made at the urethrovesical junction or so-called bladder neck. The second bite is made deeply into the vaginal wall at the junction of the middle and proximal thirds of the urethra. The third bite then is made into the vaginal wall at the junction of the middle and distal thirds of the urethra. The needle then is placed deeply into the fibrocartilage of the symphysis pubis (not the periosteum as originally described). (Figure 1) This procedure then is repeated on the opposite side of the urethra. During the actual tying of the sutures the assistant continues to elevate the anterior vaginal wall to decrease all tensions and thereby preventing any breakage or tearing out of the sutures as they are tied. A Penrose drain is placed in the Retzius space. The Foley catheter is removed and a suprapubic drainage is placed in the bladder after closure of the incision.

### Comment

Through the years the Marshall-Marchetti-Krantz procedure has proved to be one of the most important contributions to the surgical management of stress incontinence. The purpose of this communication is to illustrate a

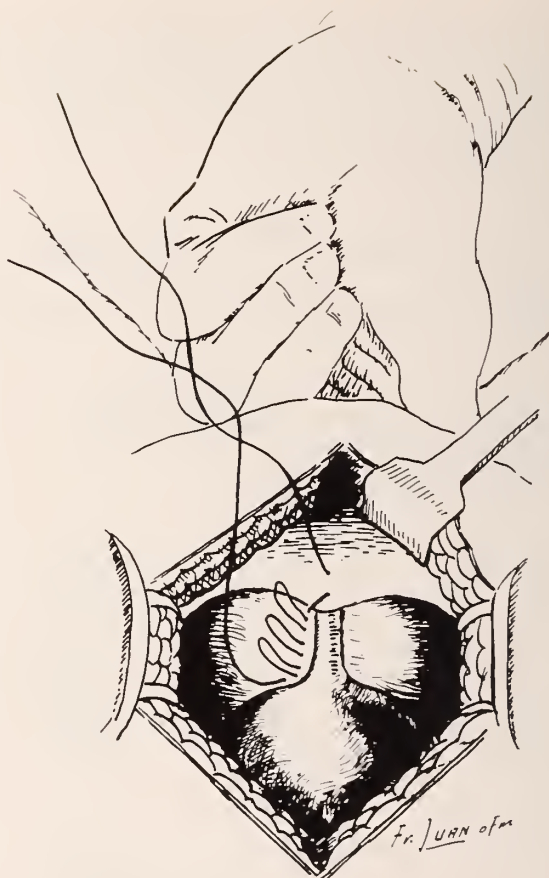


Figure 1 — For the resuspension of the urethra and bladder neck, the first bite is made at the urethrovesical junction (bladder neck). The second bite is made deeply into the vaginal wall at the junction of the middle and proximal thirds of the urethra. The third bite is then made into the vaginal wall at the junction of the middle and distal thirds of the urethra. The needle then is placed deeply into the fibrocartilage of the symphysis pubis. This procedure is repeated on the opposite side of the urethra.

simplified technique that, in our experience, has proved to be successful.

The triple-bite, single-suture technique achieves the resuspension of the urethra and bladder neck using only one suture on each side of the urethra as compared with an average of three sutures when the standard procedure is used. It has the advantage of simplifying the operation, saving time, preventing the confusion of multiple sutures. Also, there is less tissue manipulation, decreased blood loss from this highly vascular area and reduced possibility of infection. Inasmuch as only two sutures are placed in the symphysis pubis, the opportunity for the

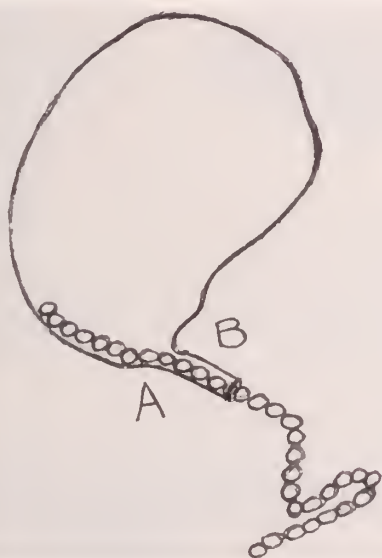




Left



Right



**Figure 2**—Case Example: A 40-year-old woman, gravida 2, para 2 who complained of urinary stress incontinence of four years' duration. The preoperative chain cystourethrogram revealed a Type II stress incontinence at left with complete loss of the posterior urethrovesical angle (A) and rotational descent of the urethral axis with an angle of inclination to the verticle greater than 45 degrees (B). The postoperative film at right following the "triple-bite, single-suture technique" reveals the restoration of normal posterior urethrovesical angle (A) and the normal urethral axis of inclination (B) with relief of the stress incontinence.

development of osteitis pubis is diminished.

The elevation of the urethra and the vesicourethral angle is excellent as is demonstrated in our patients through the use of preoperative

and postoperative metallic chain cystourethrogram.

In the past eighteen months we have performed the triple-bite, single-suture technique on 23

patients. All of the patients had a preoperative chain cystourethrogram to document a Type II anatomical defect. The postoperative chain cystourethrogram in all 23 cases invariably shows the normal restoration of the posterior urethrovesical angle and urethral axis. Figure 2 shows the x-ray study in a 40-year old female who had urinary stress incontinence for four years.

At present all patients are asymptomatic. Although this series of patients is small with relatively short follow-up, we consider the advantages of this modified technique to be evident.

Martland Hospital Unit, CMDNJ, Newark

## References

1. Green TH Jr: Development of a plan for the diagnosis and treatment of urinary stress incontinence. *Am J Obstet Gynecol* 83:632, 1962.
2. Pelosi MA, Apuzzio JJ, Frattarola MA, Hung CT, Caterini H: A diagnostic device for stress incontinence. *Obstet Gynecol* 45:223, 1975.
3. Green TH Jr: Urinary stress incontinence: Differential diagnosis, pathophysiology, and management. *Am J Obstet Gynecol* 122:368, 1975.
4. Marshall VF, Marchetti AA, Krantz KE: The correction of stress incontinence by simple vesico-urethral suspension. *Surg Obstet Gynecol* 88:509, 1949.

## Too Much Violence on TV

A survey of American physicians showed that 94 percent of those polled believe there is too much violence on television. And half of those suspect that the effects of TV violence may be showing up in their office and hospital, according to a study conducted by the American Medical Association.

One key question asked was: Have any of your patients presented behavioral symptoms and/or physical problems that may be related to TV violence? Though only 13.6 percent of the responding physicians answered yes, another 40.6 percent said they "suspect so." Twice as many children present such symptoms as the population at large, the doctors said.

Examples of behavioral and medical problems doctors cited that may stem from exposure to TV violence include heightened aggression in

children, injuries resulting from emulating television incidents, epileptic seizures, and nightmares.

One doctor said he cared for two children who jumped from a roof playing Batman. Another said a child he knew set his house on fire, copying an arson incident seen on TV. And a third physician said he saw the consequences of a child playing police with a loaded gun after watching a television show.

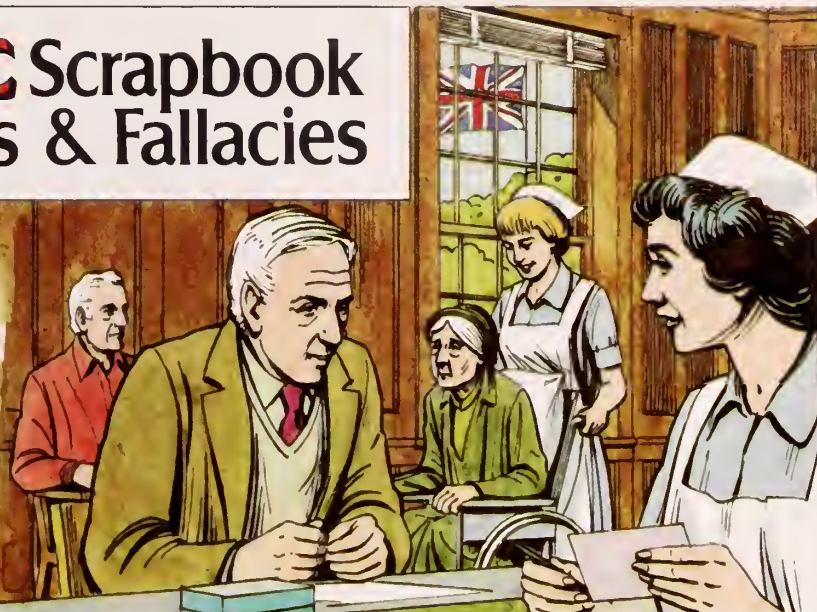
Asked to rate effectiveness of four techniques for reducing TV violence in America, physicians gave top rating to refusal to buy sponsors' products. Letters of complaint to networks and sponsors placed second, government regulation of program content was third, and boycotting of certain programs and networks was fourth.



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Griffiths, L.L., Brocklehurst, J.C., MacLean, R. et al.  
Diet in Old Age, Brit. Med. J., 1 739, 1966.



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phenobarbital (warning, may be habit forming)		
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hydrocortisone acetate	0.0065 mg	0.0065 mg

**Indications:** Based on a review of this drug by the NAS, NRC and/or other Federal or State FDA has classified the following indications as possibly effective, effective, or therapeutic for the treatment of peptic ulcer, the treatment of the inflammatory and irritable colon, spastic colon, mucous colitis) and the enteritis. Federal classification of the less-than-effective indications is not provided.

**Brief summary.** Contraindicated in patients with glaucoma, renal or hepatic disease, obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy) or a hypersensitivity to any of the ingredients. Blurred vision, dry mouth, difficult urination, and flushing or dryness of the skin may occur at higher dosage levels, rarely at the usual dosage.

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*The treatment of established disease is extraordinarily costly. A more economical and effective approach is disease prevention by risk factor modification or early intervention. A simple program for ostensibly healthy adults is suggested including: yearly hemoglobin and over age 40 hem-occult\*, seat belt use; cigarette use limitation; breast examinations; cholesterol, PAP smear and blood pressure determination every two years; rectal examination every three years and proctoscopy every six years after age 50. The annualized cost of the program is approximately \$35. Routine physical examination, chest x-ray, cardiogram, blood sugar, and urinalysis are not recommended.*

## Program for Risk Factor Modification and Selective Screening for Ostensibly Healthy Adults\*

**D. B. Louria, M.D.; M. A. Lavenhar, Ph.D.;  
M. A. Quinones, Ph.D.;  
D. J. Schneider, M.S.W. and  
J. D. Foster, B.A., Newark**

There is increasing uncertainty about the efficacy of so-called multiphasic screening from two points of view, cost:benefit ratios and the extent of modification of the incidence or outcome of serious diseases.<sup>1,2</sup> The burgeoning debate over annual examinations has several undesirable aspects. First, it is being conducted in considerable part in the mass media and the evidences used to buttress the negative positions tend to be superficial and at times very selective. For example, it is easy to inveigh against proctoscopy for early detection of bowel cancer, but the argument is highly biased if there is not simultaneous consideration of potential cancer prevention by polypectomy performed at the time of proctoscopy. Second, the current debate is thoroughly confusing to the public; if allowed to continue it irreparably will harm the field of preventive medicine, and promote nihilism that may persist even as potentially dramatic advances in early detection of disease are being explored. Third, it is thus far a largely negative argument. The annual check-up has been denigrated; but the authors and the medical profession have not offered a program that does make sense and is worthy of vigorous implementation. Fourth, the focus is on early intervention (secondary prevention) rather than on this plus risk factor modification (primary and secondary prevention).

We recently have reviewed those diseases in adults (excluding those resulting from lack of proper immunization and those occupationally related) that can be clearly modified by primary and secondary techniques,<sup>3</sup> and have developed a tentative program of risk factor modification and screening based on those data. Primary prevention is modification of or removal of risk factors resulting in reduced incidence of disease. Secondary prevention is early intervention, particularly in asymptomatic stages, resulting in a clear difference in outcome when compared to the outcome if treatment is delayed until the disease complex is established.

If a program of risk factor modification and screening for ostensibly healthy adults is to succeed it must have the following characteristics:

- (a) relatively simple
- (b) broadly applicable
- (c) reasonable likelihood for high compliance rates
- (d) inexpensive
- (e) every component supported by enough evidence that it is not open to serious challenge

If the program is so extensive that it is cumbersome, if it is not easy to apply to the entire adult population, if it has elements that are obviously unappealing to consumers, or if it is expensive, it will not succeed.

The following nine-point program appears to us

\*From the Department of Preventive Medicine and Community Health, New Jersey Medical School, Newark, New Jersey.



to meet these criteria. Each point can be defended reasonably well by the accumulated evidence. Each point, if followed, will reduce markedly the incidence of or serious consequences of the entity related to it.

We believe there is no evidence that there are additional measures that need to be added to this list other than a small number of items, specifically discussed, that possibly merit inclusion.

In the following presentation, we shall list the nine points with a brief justification for each, discuss a small number of suggested additions to the list, examine what is deliberately not recommended and analyze the cost of the program in comparison with currently recommended screening and yearly check-up programs.

#### The Nine-point Program Recommended

1. *Papanicolaou (PAP) smear every two years after age 25.* The polar views are: (a) no prospective study has unequivocally shown that the drop in cervical cancer death rates are due to PAP smears, and (b) PAP smears are so effective that they should be carried out every six months starting at age 20 or before.

Despite the doubts about the efficacy of PAP smears, the data suggest that screening has indeed reduced mortality; in the study by Kinlen and Doll, the decreased mortality was found in the age group 45-64, the period in which most cervical carcinomas occur.<sup>4</sup> Most persuasive is the finding by Christopherson and Parker that the ratio of carcinoma *in situ* to invasive carcinoma increased during screening from 0.15:1.00 to 2.57 to 1.0.<sup>5</sup>

Assuming that PAP's are indicated, the derivative question asks how often and starting at what age. Hakama and Räsänen-Virtanen found that obtaining a PAP only once every five years reduced the anticipated incidence of invasive cervical cancer by 79 percent; this represented over 90 percent of the drop that could be achieved by yearly screening.<sup>6</sup> We believe that a PAP smear every other year, if the initial results are negative, is a reasonable

approach especially if the more sensitive split-specimen technique recently suggested is utilized. Although a small proportion of the cervical carcinomas occur before the age of 25, the overwhelming majority of cases occur after that age and this, therefore, should be the target population.

2. *Breast examination yearly by a trained individual and self-examination every three months after age 30.* There is one impressive study indicating that repeated screening results in a reduced mortality in the 50-59 year age group (but not in the 40-49 year old group).<sup>7</sup> Both palpation and mammography contributed independently to the reduced mortality.

This single prospective study warrants the inclusion of breast palpation in our program. The yield under age 30 is so small that this appears to be an appropriate age to start. Mammography is expensive and controversial; it is, therefore, not included as highly recommended until further data are available. However, it should be noted that mammography appeared to contribute more than palpation to the reduced mortality.<sup>7</sup> Consequently, until the relationship between risk of possible cancer induction and the benefits of early cancer detection is better defined, we list mammography every two years after age 50 as optional, but not recommended. Most physicians would have women examine their breasts monthly. Whether this frequency is needed is uncertain and there is a risk of causing cancer phobia.

3. *Reduction in use of cigarettes to a maximum of 10 per day of the filter variety.* The relation of cigarette smoking to lung cancer, bronchitis, and heart disease is well established (although there is some continued debate about coronary heart disease). It would be nice if cigarette use were abandoned entirely but sales continue high and it is unlikely tobacco use will be discontinued. The morbidity ratios for lung cancer increase strikingly if the amount of use exceeds 10 per day.<sup>8</sup> Filters appear to reduce the likelihood of lung cancer.<sup>8a</sup> A dose relationship also appears established for cancer of the bladder<sup>9</sup> and coronary heart disease.<sup>10</sup> For the asymptomatic individual who must smoke, a reasonable



compromise would be no more than 10 filter cigarettes a day. We estimate that at least seven-eighths of the 1976 lung cancer deaths could have been avoided by adhering to the ten per day restriction.

4. *Use of seat belts by every car occupant.* Use of seat belts will save thousands of lives yearly.<sup>11</sup> It might appear the need for seat belts is so obvious that it would be inappropriate to include seat belt use as a major component of this program. However, current figures indicate that less than 40 percent of adults and less than 10 percent of children under age five are regularly properly restrained. Additionally, we found in a recent survey of a representative sample of New Jersey physicians that about half did not use seat belts regularly.

5. *Determination of blood pressure every two years.* The Veterans Administration study, among others, shows the value of treating asymptomatic individuals with a blood pressure exceeding 165/105 mm Hg.<sup>12,12a</sup>

There is no evidence that treating those with a systolic pressure of less than 165 mm Hg. and/or a diastolic pressure under 105 mm Hg. is beneficial. A two-year interval between screenings seems perfectly reasonable for the asymptomatic individual with the caveat that screening should be more frequent for those whose levels are borderline (for example, 150/90 mm Hg.).

6. *Tonometry every five years over age 35.* If glaucoma is detected early, visual loss can often be minimized or avoided. Those with increased intraocular tension have an increased likelihood of glaucoma-induced visual loss.<sup>13</sup> The time interval between screenings is not certain but an interval of five years would seem reasonable if initial values are normal (<21 mm Hg.). It should be emphasized that although those with intraocular hypertension have a somewhat greater incidence of glaucoma, the majority of glaucoma patients seen in a given five-year period will come from the larger pool with initially normal pressures. Consequently, ophthalmologists recommend fundoscopic examination even with a normal intraocular

tension to detect other pre-glaucomatous changes. It might, therefore, be desirable to have fundoscopic examination at the time of tonometry; if pre-glaucomatous changes are detected, yearly follow-up is advisable even if initial intraocular pressures are normal. More data are needed on the importance of funduscopy findings suggesting possible subsequent glaucoma in those with normal intraocular tensions.

7. *Hemoglobin.* The argument for determining hemoglobins in asymptomatic individuals is that nutritional anemia is frequent in the United States,<sup>14</sup> and may affect functioning. The symptoms may be so subtle, however, that the anemic individual continues to function, albeit unsatisfactorily, believing he is in point of fact asymptomatic.

There is no evidence that the detection of anemia in asymptomatic patients with cancer changes the outcome of the disease.

In view of the frequency of nutritional deficiency and the ease with which it can be corrected in most cases, we recommend a hemoglobin determination every year for ostensibly healthy persons.

8. *Cholesterol.* There are still those who believe that cholesterol concentrations are not related to the risk of coronary heart disease, but the Framingham study,<sup>10</sup> among others, appears convincingly to show that the risk of coronary heart disease is directly related to the level of serum cholesterol. Those whose concentrations are less than 220 mg/dl are at low risk, whereas the relative risk for those with cholesterol levels of 250 mg/dl is much greater. The incidence of coronary heart disease was roughly tripled in men 30-49 years of age on entry to the Framingham study whose cholesterol was 260-279 mg/dl. Cholesterol level was as good as any other lipid value as a predictor of coronary heart disease. There is no convincing evidence that elevated triglycerides are a significant risk factor for coronary heart disease if the serum cholesterol levels are not elevated. There are some still unsettled data suggesting that lowering the cholesterol in

those with angina may avert a severe coronary episode.<sup>15a,b</sup> It is not clear how frequently a cholesterol level should be determined. It seems sensible to us to determine the cholesterol concentrations every other year if levels remain under 220 mg/dl. If levels are above 220 mg/dl they should be checked yearly and appropriate measures taken to reduce levels if they climb above 250 mg/dl.

9. *Guaiac Test for occult blood in stool.* The conventional recommendation for secondary prevention is that proctoscopy should be performed yearly after age 40 in order to detect rectal-colon cancer early enough to achieve high cure rates. The recommendation is made in considerable part because colon-rectal cancer is the second leading cause of cancer deaths in both men and women. In 1976, according to the American Cancer Society, an estimated 99,000 persons developed colon-rectal cancer and 49,200 died of these carcinomas.

The question is how effective is proctoscopy? Certainly, if the tumor is detected in a localized stage, five-year survival rate is much better when compared to five-year survivals for all stages. Among men age 45-54 on entry to the Kaiser-Permanente clinic who underwent proctoscopy, seven-year mortality from bowel cancer was significantly reduced.<sup>16</sup> In this study, proctoscopy was performed routinely, but stool examination for occult blood was not carried out.

Is proctoscopy better than testing for occult blood for detection of colon-rectal cancer? There is no evidence that it is. About 50 percent of colon cancers can be seen at proctoscopy, providing the examiner can visualize a full 25 cm of the bowel. Greigor reported that guaiac-impregnated slides (hem-occult®) detected 135 of the 136 colon-rectal cancers if a high bulk, low meat diet was followed starting 24 hours before collection of the specimen from three consecutive evacuations.<sup>17</sup> Of 47 asymptomatic cancers in that series, only four were in range of the sigmoidoscope. The conclusion from these and other studies seems inescapable: that three stool specimens obtained properly and tested with hem-occult® is every bit as good as

proctoscopy. Sigmoidoscopy will rarely detect a cancer missed by studies for occult blood and far more often the hem-occult® test will detect cancers missed by proctoscopic examination. Even if, on rare occasion, sigmoidoscopy reveals a cancer not found by testing for occult blood, there is no evidence this alters five-year mortality rates. Routine proctoscopy for cancer cannot be justified. The argument for proctoscopy must then be based on the assumption that polyps may be premalignant, and that the majority of polyps are in the range of the 25 cm sigmoidoscope. Gilbertsen performed routine polypectomy in 18,158 persons over a 25-year period and reported that only 11 cancers were found subsequently, although 75-80 were expected in this patient population.<sup>18</sup> He believes that proctosigmoidoscopy should be performed every two to three years after age 50, but in point of fact, his own data suggest that a proctoscopy every seven years might be as efficacious. However, the relationship of polyps to cancer is unsettled and the role of polypectomy at best is only suggestive.

Our recommendation is yearly study by hem-occult® test of three consecutive stools collected after an appropriate diet, for each person over age 40. It is possible that swabbing the peri-anal area after an evacuation and applying the swab to a hem-occult® slide may be as effective as the less aesthetic technique of placing a piece of stool on the slide.

It seems to us that proctoscopy every five to seven years after age 50 should be recommended but considered optional for the non-high risk individual. High risk individuals are those with a family history of polyps, ulcerative colitis, and so on and presumably proctoscopy should be done regularly in such patients.

*Procedures considered for inclusion but presently not included*

(a) *Weight*—Should yearly weight be part of the program? Perhaps the answer is yes. If an overweight individual has hypertension, weight loss alone may reduce the blood pressure levels, but it is more direct to follow the blood pressure and attend to overweight if hypertension is detected. It is unclear whether weight per se is a

risk factor for coronary heart disease.<sup>10,19</sup> Certainly, it is a minor factor compared to three major risk factors: hypercholesterolemia, hypertension, and smoking.

Excessive weight can unmask diabetes and conversely, in an overweight adult with overt diabetes, weight reduction alone can control the diabetes and often return the glucose tolerance curve to normal.<sup>20</sup> At present, however, there is no evidence that reducing the weight before the diabetes becomes symptomatic makes any difference in outcome and/or severity of complications compared to reducing the weight after the diabetes has become symptomatic. There is obviously nothing wrong with adding a yearly weight determination to the nine basic points but the long-term benefit to the ostensibly healthy adult is not firmly established.

(b) *Pelvic examination for ovarian carcinoma* — Ovarian carcinoma killed an estimated 10,800 women in 1976 according to American Cancer Society data. We need a sensitive test to detect this tumor before it has spread beyond the ovary itself, but physical examination is not that test. Every gynecologist will provide anecdotal evidence of detection of ovarian carcinomas in localized stage by physical examination of asymptomatic women. Five-year survival for those with localized disease is 70 percent compared to a five-year survival of about 30 percent for non-localized disease. Only one ovarian cancer will be detected in every 10,000 pelvic examinations; the overwhelming majority, even in asymptomatic individuals, will show at least local extension.<sup>21</sup> Conversely, in some patients with symptoms, the disease will be found to be localized at operation. The value of the yearly pelvic examination for detection of asymptomatic ovarian cancer as public health policy is not proved.

(c) *Rectal examination for prostatic or rectal cancer* — As indicated previously, the guaiac test for occult blood in the stool is as good as rectal examination in the detection of bowel carcinoma. The rectal examination is virtually a sacrosanct component of the annual check-up. It is at present the only way to detect car-

cino-ma of the prostate in the early stages when the cure rate by radical prostatectomy is very great. However, 50 percent of men over age 50 have prostatic cancer at autopsy; most often the disease does no harm. Of those cases detected by yearly rectal examination, the majority are in the more advanced and less curable stages when detected.<sup>22</sup> Additionally, the best study to date casts serious doubt on the value of routine rectal examination for prostatic cancer. The numbers involved were small (about 60-70 in each group in the critical studies) but the findings indicate that when localized disease is detected, either by physical examination or during the course of operation for benign prostatic hypertrophy, the 10 to 15-year survival rate is no different among the following therapeutic groups: radical prostatectomy with or without estrogens; placebo versus prostatectomy; placebo versus estrogen therapy.<sup>23a,b</sup> Thus, at present, it is unclear whether detection of a prostatic nodule really makes any difference to the patient. Recent data, not yet buttressed by adequate prospective, controlled studies, suggest that survival may be improved by use of intensive local radiation<sup>24</sup> or injection of radioactive iodine. If rectal examination is to be done, in view of the slow growth of prostatic tumors, it would be reasonable to recommend the examination once every three years after age 50.

#### *Procedures not recommended*

(a) *Blood sugar*. There is no evidence that detecting diabetes in its pre-symptomatic phases improves the prognosis compared to detecting and treating the diabetes only after symptoms have appeared.

(b) *Urinalysis*. In the healthy, non-pregnant adult, the finding of asymptomatic proteinuria or pyuria does not improve the prognosis of urinary tract infection, nephritis or any other disease when compared to treating only after symptoms supervene.

(c) *White blood count and differential count*. There is no evidence of benefit in detecting and treating any asymptomatic disease entity revealed by this test.



(d) *Routine physical examination.* It is advisable for every adult to have a physical examination once as a baseline but, thereafter, the examination for the asymptomatic adult is, for the most part, a waste of time.<sup>25</sup> It is difficult to find any disease acquired in adulthood that would benefit from treatment during its pre-symptomatic stages after being detected on routine physical examination.

(e) *Chest x-ray.* Current studies are attempting to assess the value of routine chest x-ray in detecting early lung cancer in asymptomatic high risk individuals, i.e., those who have a history of substantial cigarette use. It well may be that in these individuals the routine chest x-ray will enable the physician to detect cancer when the tumor is localized and that extirpation at that time will significantly increase length of survival. However, the data collected thus far on routine chest x-rays performed yearly or even more frequently do not show any significant increase in five-year survival rate from lung cancer, even in so-called high risk individuals.<sup>26</sup> If an individual smokes over one-half a pack daily and has been doing so for at least ten years, chest x-ray every six months deserves consideration, but the data are not yet convincing. For the light smoker or the non-smoker, the chest x-ray is a waste of time. There are those who still feel an x-ray is desirable to detect tuberculosis. However, the person with early tuberculosis without cough is not contagious; there is no evidence that treating pulmonary tuberculosis in the presymptomatic phase results in a more predictable or more rapid recovery compared to treating the disease once the patient develops symptoms such as cough, fever, and expectoration. It would seem desirable to have one chest x-ray as an adult as a baseline.

(f) *Electrocardiogram.* There is really nothing that would be detected on the cardiogram of an asymptomatic individual that would require intervention except for evidence of coronary heart disease or hypertensive heart disease, and these would be analyzed better by determining blood pressure and serum cholesterol. On rare occasions, a severe arrhythmia will be detected that has not been noted by the patient but, for

the most part, the patient is aware of the arrhythmia. Routine electrocardiograms cannot be justified by the rationalization that significant treatable arrhythmias will be detected in apparently healthy asymptomatic adults. As with a chest x-ray one electrocardiogram should be taken and should be available for future reference.

### Cost

The cost of the nine-point program on an annualized basis determined by reimbursement for individual tests by insurance carriers in the State of New Jersey is about \$35. In contrast, the nine-point program plus general physical examination (\$29), chest x-ray (\$17), electrocardiogram (\$22), blood glucose (\$5), urinalysis (\$4), white blood cell count and differential count (\$5), blood urea nitrogen (\$5) and proctoscopy (\$25) costs the patient \$137, which is a minimal figure.

### Discussion

The program outlined is based on our perception of the data available to us. We have summarized the program in Table I. Obviously, the intervals chosen between tests represent somewhat arbitrary judgments on our part. It is impossible to be rigid about this or other programs. Rather they should be presented so that the medical profession can reach a consensus as to what programs make sense on the basis of current evidence, ease of implementation, and practicality. It is equally important that whatever program receives approval then should be applied to a defined population using different health education strategies. Health education efforts have been notoriously ineffective. Part of the problem resides in failure to test the efficacy of various strategies and messages. In some cases fear messages are effective; in other instances they are counter-productive.<sup>27,28</sup> Yet, for the most part, physicians "educate" without regard for the possibility that the nature of the message may be disadvantageous for a given audience. In addition to assessment of the most effective type of message to implement a risk factor modification and early intervention program, careful

follow-up studies will be needed to determine the effect of health education programs on target population knowledge and attitudes. Additional assessment will have to be made of two outcome measurements—compliance with the advocated program components and effect on disease patterns. Only then can the program be applied more broadly.

If health education efforts in regard to disease prevention and early intervention are to succeed, physicians will have to be heavily involved since they are viewed by the public as the best sources of health information.

The medical profession must take the lead in translating any program into school health education curricula and into vigorous and evaluated school and community-based prevention endeavors. Additionally, physicians must set a good example by following the program components.

If the rectal examination and proctoscopy are eliminated or performed only every three to six years, then the program can be implemented for the most part by well-trained non-physicians. A nurse practitioner could, for example, do both the PAP smears and breast examination. This would free the physician to focus on high-risk individuals such as heavy smokers or those with a history of familial polyposis. Rather than urging adults to have regular examinations by physicians we then could urge the public to follow a program such as the one outlined herein and to see the physician only if persisting and/or serious signs and symptoms supervene.

If this or a similar program is adopted and vigorously implemented, it would be important for those companies offering medical insurance to reduce premiums for those following the programmatic components. To enhance compliance each person could be given his or her own health calendar and could be urged to comply with the program in the month in which that individual's birthday occurs. Each person could have a 10-year calendar with studies to

be completed listed for each of those years.

It is intriguing that there are so few items in the program, and although each of the points can be defended, more data are needed on two of the nine points—further studies could show that detection of asymptomatic lumps in the breast or finding blood in the stool of apparently healthy persons makes no difference in the five to ten year survival percentage in patients with tumors of the breast or bowel.

If a specific program is accepted for public health policy, that program must be flexible. We are advocating a nine-point program with two additional studies recommended but still listed as optional. We are also considering adding two other components if evidence can be adduced to justify their inclusion (weight and pelvic examinations). Surely, the list will change with time both in number of items and in the intervals between determinations. New tests are being developed that may literally revolutionize secondary prevention. For example, radioimmuno-assay analysis of serum acid phosphatase may be able to detect prostatic carcinoma in its earliest stages. It seems to us that new items should be added to the program only after they are shown convincingly to be effective.

Unfortunately, as the medical profession reappraises multiphasic screening and the general physical examination, it is receiving obloquy from the press and some politicians. *Time* magazine headlined its July 26, 1976 article "The Annual Rip-Off?" In point of fact, the data on multiphasic screening are just becoming available on which to make proper judgments concerning future directions. It is now a propitious time to reexamine our approach to primary and secondary prevention. We must have consensus on a national program that can be utilized for health education efforts in schools and communities. We believe the proposed program is a reasonable starting point for a dialogue that could culminate in a pragmatic national policy for risk factor modification and early intervention.

Table I  
Primary and Secondary Prevention Program  
for Asymptomatic Adults

<i>Highly Recommended</i>	
Hemoglobin	Yearly
Hem-occult <sup>®</sup> for intestinal bleeding	Yearly after age 40
Intraocular tension	Every 5 years after age 35
Seat belt use	
Cigarettes reduced to 10/day	
Pap smear	Every 2 years after age 25
Breast examination	Self-examination every 3 months after age 30 Yearly examination by expert
Blood pressure	Every 2 years
Cholesterol	Every 2 years
<i>Optional</i>	
Weight yearly	Control mostly for appearance, and for feelings of well-being
Pelvic yearly after 50 for ovarian cancer	Not cost effective, benefit uncertain
Rectal examination	Every 3 years after age 50; benefit not fully proved. Recommended.
Proctoscopy	Every 6 years after age 50; benefit uncertain. Recommended.
Mammography	Every 2 years after age 50; controversial.
<i>Not Recommended</i>	
Routine physical examination	One baseline examination recommended.
Electrocardiogram	One baseline examination recommended.
Blood urea nitrogen	
Chest x-ray	One baseline examination recommended.
Blood glucose	
Urinalysis	
White blood count and differential	

## References

- Spitzer WO and Brown BP: Unanswered questions about the periodic health examination. *Ann Intern Med* 83:257-263, 1975.
- Spark R: The case against regular physicals. *New York Times Magazine*, July 25, 1976.
- Louria DB, Kidwell AP, Lavenhar MA, Thind IS and Najem GR: Primary and secondary prevention among adults: An analysis with comments on screening and health education. *Prev Med* 5:549-572, 1976.
- Kinlen LJ and Doll R: Trends in mortality from cancer of the uterus in Canada and in England and Wales. *Brit J Prev Soc Med* 27:146-149, 1973.
- Christopherson WM and Parker JE: Economic considerations of the control of cervix cancers in high risk patients. *CA* 19:107-111, 1969.
- Hakama M and Räsänen-Virtanen U: Effect of a mass screening program on the risk of cervical cancer. *Amer J Epidem* 103:512-517, 1976.
- Shapiro S: Screening for early detection of cancer and heart disease. *Bull NY Acad Med* 51:80-95, 1975.
- Wynder EL and Mabuchi K: Etiological and preventive aspects of human cancer. *Prev Med* 1:300-334, 1972.
- Wynder EL and Hoffmann D: Less harmful ways of smoking. *J Nat'l Cancer Instit* 48:1749-1758, 1972.
- Cole P, Monson RR, Haning H and Friedell GH: Smoking and cancer of the lower urinary tract. *New Engl J Med* 284:129-134, 1971.
- Kannel WB and Dawber TR: Contributors to coronary risk implications for prevention and public health: The Framingham Study. *Heart and Lung: J Crit Care* 1:797-809, 1972.
- Huelke DF, Sherman HW and O'day J: The hazard of the unrestrained occupant. University of Michigan Highway Safety Research Institute, Proc 18th Conference Amer Asso Automotive Med, 1974.
- Veterans Administration Cooperative Study Group on Anti-hypertensive Agents. Effects of treatment on morbidity in hypertension: Results in patients with diastolic blood pressures averaging 115 though 129 mm Hg. *JAMA* 202:1028-1034, 1967.
- Veterans Administration Cooperative Study Group on Anti-hypertensive Agents. Effects of treatment on morbidity in hypertension. II. Results in patients with diastolic blood pressure averaging 90 through 114 mm Hg. *JAMA* 213:1143-1152, 1970.
- Armaly MF: Glaucoma. *Arch Ophthalmol* 93:146-162, 1975.
- Preliminary findings of the First Health and Nutrition Examination Survey United States 1971-1972. US Department of HEW. DHEW Pub # HRA 74 1219-1, January 1974.
- Trial of clofibrate in the treatment of ischaemic heart disease. Five year study by a group of physicians of the Newcastle Upon Tyne Region. *Brit Med J* 4:767-775, 1971.
- Ischaemic heart disease, a secondary preventive trial using clofibrate. *Brit Med J* 4:775-784, 1971.
- Dales LG, et al: Multiphasic check-up evaluation study: Outpatient clinic utilization, hospitalization and mortality: experience after seven years. *Prev Med* 2:221-235, 1973.
- Greegor DH: Detection of colorectal cancer using guaiac slides. *CA* 22:360-363, 1972.
- Gilbertsen VA: Proctosigmoidoscopy and polypectomy in reducing the incidence of rectal cancer. *Cancer* 34:936-939, 1974.
- Keys O, et al: Coronary heart disease: overweight and obesity as risk factors. *Ann Intern Med* 77:15-27, 1972.



20. Boshell BR, Chandalia HB, Kriesberg RA and Roddam RF: Serum insulin in obesity and diabetes mellitus. *Am J Clin Nutr* 21:1419-1428, 1968.
21. Drukker BH and Hodgkinson CP: Ovarian carcinoma. Perspective for the 70's. *Amer J Obstet Gynecol* 109:825-837, 1971.
22. Gittes RF and Chu TM: Detection and diagnosis of prostate cancer. *Seminars in Oncology* 3:123-130, 1976.
23. Veterans Administration Cooperative Urological Research Group Statistical Report for Semi-Annual Meeting, St. Louis, MO, May 16, 1974.
- 23a. Veterans Administration Cooperative Urological Research Group Statistical Report for Semi-Annual Meeting, Washington, DC, May 1, 1973.
24. Pistenma DA, Ray GR, Bagshaw MA: The role of megavoltage radiation therapy in the treatment of prostatic carcinoma. *Seminars in Oncology* 3: 115-122, 1976.
25. Harnes JR: Second and subsequent periodic examinations. *NY State J Med* 76: 891-897, 1976.
26. Boucot KR and Weiss W: Is curable lung cancer detected by semi-annual screening? *JAMA* 224:1361-1365, 1973.
27. Higbee KL: Fifteen years of fear arousal: Research on threat appeals. 1953-1968. *Psych Bull* 72:426-444, 1969.
28. Janis IL and Fishbach S: Effects of fear-arousing communication. *J Abnormal Soc Psych* 48:78-92, 1953.

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those who have died in order that  
we might meet here in freedom and  
safety to create it.'

"If we seek to use it selfishly—for  
the advantage of any one nation or  
any small group of nations—we  
shall be equally guilty of that be-  
trayal."

Fervent Interpolation

The President, speaking in the  
auditorium of the War Memorial  
Opera House, built in memory of  
sons of the Golden Gate city who  
gave their lives in the first World  
War, in which he himself served,  
seemed to give unconscious expres-  
sion to the solemn feeling of the  
occasion when, at the outset of his  
speech, he interpolated the words,  
half a hope, half a prayer:  
"Oh, what a great day this can  
be in history!"

# Social Security Bill Is Signed Gives Pensions to Aged, Jobless

Roosevelt Approves Message Intended to Benefit 30,000,000  
Persons When States Adopt Cooperating Laws—He  
the Measure 'Cornerstone' of His Economic Program

## SENATE APPROVES 18-YEAR OLD VOTE IN ALL ELECTIONS

Amendment to Constitution  
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today 94 to 0, and sent to

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The Social Security Bill,  
a broad program of unemploy-  
ment insurance and old age  
pensions and counted upon to ben-  
efit 20,000,000 persons, became law  
today when it was signed by Presi-  
dent Roosevelt in the presence of  
those chiefly responsible for drafting  
it through Congress.

Mr. Roosevelt called the bill  
"the cornerstone of my economic  
program which is being built to  
meet the complete needs of the  
people."

# the Draft Ends No

WASHINGTON, Jan. 27,  
1973—"With the signing of  
the peace agreement in  
Paris today, and after re-  
ceiving a report from the





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# PATIENT PACKAGE INSERTS: A CONCEPT WHOSE TIME HAS COME?

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*The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely-prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.*

*The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.*

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## **The Disadvantages**

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information

is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

## **The Solution**

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.

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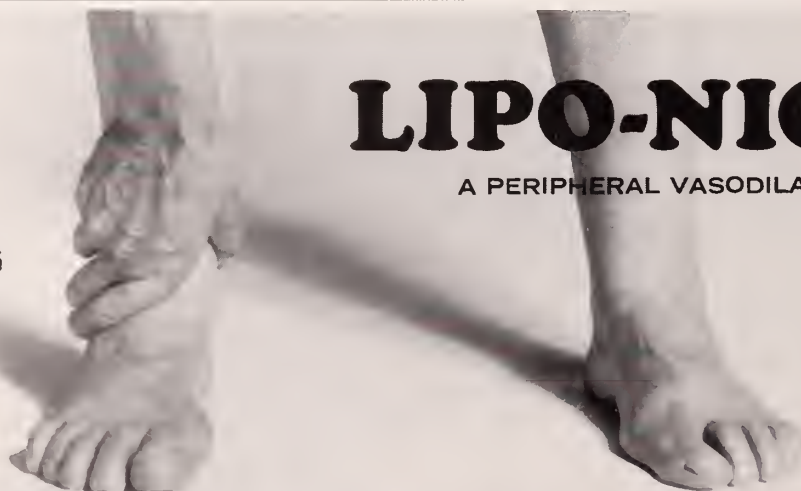
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# CASE REPORTS

*Two children with ALTB progressed to respiratory failure despite standard conservative management. In each, endotracheal intubation was performed. Subsequent extubation was not tolerated and tracheostomy was done. Removal of the tracheostomy tube was easily accomplished several days later.*

## Endotracheal Intubation in Acute Laryngotracheobronchitis

**Nasser Rahbar, M.D.**  
**Venkatesan Krishnan, M.D., and**  
**Richard H. Rapkin, M.D., Piscataway**

The management of respiratory failure in acute laryngotracheobronchitis (ALTB) and epiglottitis (EPG) has had much attention in the recent pediatric literature. The question of when and how to provide an artificial airway in EPG seems to have been resolved by studies which have demonstrated the effectiveness of nasotracheal intubation<sup>1,2</sup> and the importance of prompt intervention upon diagnosis.<sup>3,4</sup> In ALTB, however, the ideal method of maintaining the airway when respiratory failure occurs remains doubtful.<sup>5</sup> It is generally agreed that tracheostomy is effective,<sup>6</sup> but others have found nasotracheal intubation valuable.<sup>7-10</sup> In one series, however, the complication rate was inordinately high after nasotracheal intubation.<sup>7</sup>

*Case I.* A five-month-old female was transferred to CMDNJ-RMS-Raritan Valley Hospital on January 19, 1976 for care of croup.

The child was well until one week prior to admission when she developed fever and an upper respiratory infection, which was treated symptomatically. Five days prior to transfer she had a croupy cough and stridor. Ampicillin by mouth was begun. The next day, the cough worsened; an x-ray showed increased bronchovascular markings so she was admitted to a local hospital. Ampicillin (90 mg/kg/day I.M.) and dexamethasone (1 mg/kg/day I.M.) were given. Gradual improvement occurred until the night prior to transfer when she developed respiratory distress with marked stridor. There was no response to epinephrine administered by an intermittent positive pressure breathing device, so nasotracheal intubation was performed with prompt relief of the distress. The epiglottis was noted to be normal by the endoscopist. Past history and family history were noncontributory except that the patient's mother had a "virus" with hoarseness two weeks prior.

Physical examination revealed a well-developed, well-nourished child in no distress with a nasotracheal tube in place. The temperature was 100° F., the respiratory rate 28

per minute, the pulse 130 per minute. There were no abnormal findings.

The chest x-ray, complete blood count, urinalysis, nose, throat, and blood cultures were normal. Ampicillin and dexamethasone were omitted, and the nasotracheal tube was removed. The child tolerated extubation, but gradually became increasingly distressed; twenty hours later she was in major respiratory distress. Arterial blood gases with an  $\text{FiO}_2$  30 percent were  $\text{pO}_2$  45,  $\text{pCO}_2$  51,  $\text{pH}$  7.27. She was reintubated with a 4.5 mm straight endotracheal tube with immediate relief of distress.

Intubation was maintained for seventy-two hours, following which the patient was extubated. Within forty-five minutes, she became severely distressed and cyanotic; she was reintubated with a 3.5 mm tube and was immediately relieved. Four hours later, an elective tracheostomy was performed. The child did well with the tracheostomy, so six days later the size 0 tracheostomy tube was replaced with a size 00 tube. Twenty-four hours after that she was extubated and was discharged seventy-two hours later in good condition.

*Case II.* A six-week old female was transferred to CMDNJ-RMS-Raritan Valley Hospital on February 27, 1976. She had been well until four days earlier when she developed a mild upper respiratory infection with cough. Hoarseness occurred two days later and, on the next day, respiratory distress with tachypnea and retractions were noted. The child was admitted to a local hospital because of the progressive increase in distress. Ampicillin (110 mg/kg/day I.M.), dexamethasone (1 mg stat I.M.), and epinephrine with intermittent positive pressure respiratory assistance were administered without improvement. A straight endotracheal tube measuring 4 mm was inserted; the epiglottis was seen to be normal. The child was transferred to Raritan Valley Hospital.

The child had been the product of a full-term pregnancy and an uncomplicated delivery. Her father had had an upper respiratory infection with cough during the previous week.

Physical examination revealed an endotracheal tube in place, pulse was 140 per minute, the respiratory rate 40 per minute, and the temperature 101° F. The height and weight were at the 25th percentile. The rest of the physical examination was normal. The chest x-ray, urinalysis, blood, urine, and throat cultures were normal. The hemoglobin was 10.4, hematocrit 29.8, white blood count 16,000, with

\*From the Department of Pediatrics, Rutgers Medical School, CMDNJ, Piscataway.

37 polys, 18 bands, 18 lymphocytes, 8 monocytes, 1 eosinophil, and 18 atypical lymphocytes.

Antibiotics were discontinued and the child did well, so she was extubated twelve hours after admission. The procedure was tolerated, but in twelve hours the child became increasingly dyspneic and cyanotic. Epinephrine, administered by an intermittent positive pressure device, led to temporary relief.

Recurrence of severe distress sixteen hours after extubation required reintubation (again with a 4 mm straight endotracheal tube) with rapid and significant improvement.

The tube was maintained for seventy-two hours and was then removed, but within one hour the child became severely distressed and required reintubation with a 4 mm tube (the largest that could be passed). The epiglottis was normal, but the trachea was markedly inflamed and edematous. Twenty-four hours later, an elective tracheostomy was done with a 00 tracheal tube. Six days later, significant air leakage was noted around the tube which was plugged. There was no adverse effect so the tracheostomy tube was removed thirty minutes later. The child did well and was discharged after another four days.

## Discussion

Our two patients had respiratory failures. Each was intubated easily and successfully and did well until extubation was attempted. Both patients then did poorly without the endotracheal tube, which had to be replaced. Neither tolerated a second attempt at extubation, so tracheostomy was done. Subsequent extubation from tracheostomy was easily accomplished.

It is uncertain whether a longer period of endotracheal intubation might have obviated the need for tracheostomy. Acute laryngotracheobronchitis can be slow to resolve; the severity of disease in these two patients probably destined them to a prolonged period of tracheal inflammation.

Did these patients have ALTB? Although younger than average for this disease the positive evidence is strong. Each had a parent with an acute respiratory disease. Neither had epiglottitis or a foreign body. Neither had evidence for diphtheria, angioneurotic edema, or retropharyngeal abscess. Neither patient had positive bacterial cultures, but viral studies were not done. Whether our patients would have done better with initial tracheostomy or as well with a longer period of endotracheal intubation is speculative. We considered the

above factors in our decision to intubate initially and subsequently perform the tracheostomies.

The endoscopist recommended tracheostomy because on observation the trachea was as narrow prior to reintubation as it had been initially and he was concerned about subsequent tracheal damage. Although intubation is preferable to tracheostomy if it is effective, it is obvious that clinical extrapolation from our two patients is not justified.

## Speculation

The cases presented fit an hypothesis which needs to be tested: Endotracheal intubation, as compared to tracheostomy, might be a poor choice in respiratory failure of ALTB. One may speculate that the tube would be placed immediately adjacent to the inflamed, edematous, and narrowed trachea; and it might then intensify or prolong the inflammation by its pressure effect. Tracheostomy, usually done distal to the area of maximal narrowing, might be less injurious to the inflamed trachea.

This clearly is not an all-or-none phenomenon<sup>8</sup>, so one must select individual treatment for each patient. Prolonging the disease slightly by endotracheal intubation in some children may be a reasonable price to pay if one can avoid tracheostomy in most. Until additional studies comparing these modalities are done, the controversy remains unresolved<sup>12</sup>.

## Summary

Two patients with ALTB and respiratory failure had endotracheal intubation. Despite attempts at extubation, tracheostomy was necessary. Subsequent extubation was then easily accomplished. The ideal artificial airway for respiratory failure in ALTB (endotracheal tube or tracheostomy) is not yet known.

## Bibliography

1. Sweeney DB, Allen TH and Steven IM: Acute epiglottitis—Management by intubation. *Anes Intens Care* 1:526, 1973.



2. Battaglia JD and Lockhart CH: Management of acute epiglottitis by nasotracheal intubation. *Am J Dis Child* 129:334, 1975.
3. Margolis CA, Ingram DL and Meyer JH: Routine tracheostomy in hemophilus influenzae type B epiglottitis. *J Pediatr* 81:1150, 1972.
4. Rapkin RH: Tracheostomy in epiglottitis. *Pediatr* 52:426, 1973.
5. Rapkin RH: Nasotracheal intubation in epiglottitis. *Pediatr* 56:110, 1975.
6. McCracken GH and Eichenwald HF: In Vaughn VC: *Nelson Textbook of Pediatrics*, Edition X. Philadelphia, Saunders, 1975, p. 964.
7. Wesley AG, Desai D, Halloway R, *et al*: Nasotracheal intubation in the management of infective croup. *S A Med J* 46:839, 1972.
8. Thomson PD and Olinsky A: Nasotracheal intubation in acute laryngotracheobronchitis. *S A Med J* 49:785, 1975.
9. Wesley AG: Indications for intubation in laryngotracheobronchitis in black children. *S A Med J* 49:1126, 1975.
10. Schuller DE and Birck HG: The safety of intubation in croup and epiglottitis. *Laryngoscope* 85:33, 1975.
11. Ferlic RM: Tracheostomy or endotracheal intubation. *Ann Otol Rhinol Laryngol* 83:1, 1974.
12. Smith RM: Diagnosis and treatment: Nasotracheal intubation as a substitute for tracheostomy. *Pediatr* 38:652, 1966.

CMDNJ—Rutgers Medical School, Piscataway

### Professional Sanctions Few for Alcoholic MD's\*

Inpatient treatment for alcohol-related problems and encounters with the law were common experiences for a group of alcoholic physicians before their recovery, but they were subjected to relatively little disciplinary action by the medical profession, according to Dr. LeClair Bissell and Robert W. Jones.

These findings, based on a study of 98 recovered alcoholic physicians, raise questions about the self-regulation of colleagues by a professional group said Dr. Bissell and Mr. Jones of the Roosevelt Hospital, New York City.

Seventy-one of the study subjects had been admitted to treatment institutions one or more times. Forty-eight had been arrested, 37 had been jailed, and 19 had lost their driver's license, according to results of a questionnaire. The study group accumulated a total of 219 arrests and 170 jailings.

On the other hand, disciplinary action applied to the 98 doctors by their profession consisted mainly of admonitions or warnings. Fifty-eight were admonished by colleagues and 20 were warned by their medical society or licensing

board. In addition, 20 lost their hospital privileges, eight lost their medical license, and one lost his narcotics license. Thirty-three experienced no professional sanctions at all, the researchers reported.

A sizable, but unrecorded, number of the physicians volunteered the opinion that their alcoholism had never resulted in injury to their patients. "Although this feeling is often shared by the colleagues of alcoholic physicians, it is a view that is difficult to accept," the researchers said. "There can be little doubt that the patients of an alcoholic physician receive a lesser level of care than that physician is able to deliver when he is sober."

The study was published in the *American Journal of Psychiatry* (Vol. 113, pp. 1142-46, 1976). More information may be obtained by writing Dr. Bissell, Chief, Alcoholism Treatment and Training Center, Roosevelt Hospital, 428 West 59th Street, New York 10019.

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\*From DHEW Publication No. (ADM) 77-151, National Institute on Alcohol Abuse and Alcoholism, Rockville, Maryland

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*The authors present a very unusual and dramatic case of an eight-week old infant who rapidly succumbed when an intestinal hemangioma resulted in intussusception, shock, and death. Literature review was relatively unrewarding for infants with this interesting combination. However, one could find a markedly greater time-lag from symptom onset until clinical disease became manifest. The high mortality rate noted in previous cases as well as in ours made reporting this a worthwhile endeavor.*

## Intestinal Hemangioma with Intussusception in Infancy

**M. N. Boulis, M.D., Stanley Karp, M.D.  
M. F. Rubinstein, M.D., Cinnaminson**

Hemangiomas of the intestinal tract are extremely rare, but have been observed in all age groups. Hemangiomas that cause intussusception occur so rarely that no one has collected sufficient experience to develop appropriate treatment. It is the purpose of this article to report a case of an intestinal hemangioma with intussusception and review the literature.

### Case Report

The patient was an eight-week-old male infant, who was delivered after an uncomplicated term pregnancy. His birth weight was 3.4 kg. and the neonatal hospital period was unremarkable except for the presence of bilateral occipital cephalhematomas. He was discharged in good condition and was subsequently seen for his first check-up at five weeks of age, at which time he was considered normal, save for resolving cephalhematomas.

At eight weeks of life, he vomited all feedings; the bowel movements were normal. He was seen approximately six hours following onset of symptoms and was noted to have adequate hydration and a soft abdomen with no abnormal masses or organomegaly.

Diet restrictions were instituted and Donnato<sup>1</sup>, five drops every six hours, was prescribed. Emesis continued and bile staining was noted by the following morning. The mother next noted a ring of pink staining on the diaper and reexamination was undertaken within two hours of this apparent passage of rectal blood. The child was afebrile but pale, tachypneic and diaphoretic with a moderately distended abdomen and absent bowel sounds.

During the examination, he passed approximately 20 cc. of clotted, mucoid blood per rectum. A "stat" hematocrit was 46 percent. Immediate hospitalization was advised and the child was evaluated by the consulting surgeon, who felt that the child was in shock as a result of significant gastrointestinal bleeding. Cardiorespiratory arrest occurred during attempts at saphenous vein cutdown for a blood transfusion. All efforts toward resuscitation failed. The time interval from onset of initial symptoms to ultimate demise was approximately 20 hours.

The gross post-mortem examination revealed a mass at the ileocecal junction. With resection, there was an ileocecal intussusception with a moderate-sized hemangioma in the distal ileum. The hemangioma caused the intussusception and this was confirmed by microscopic examination of the ileal specimen. Inspection of the remaining intestinal tract failed to reveal other hemangiomas and there were none noted on the skin.

### Discussion and Literature Review

The incidence of intestinal tract hemangiomas is relatively small in published series. Gentry, *et al.*,<sup>2</sup> reviewed 1,400,000 case records at Mayo Clinic and found only 106 cases of vascular lesions of the intestines. Of the 47 cases of hemangiomas of the gastrointestinal tract reported by Nader and Margolin in 1966,<sup>3</sup> hemorrhage was the presenting symptom in nearly 75 percent, obstruction or intussusception in 13 percent and chronic anemia in 12 percent. In their reported cases, 16 years was the average duration of symptoms before diagnosis. In many of the cases a definite age of onset of symptoms was not known, but such statements as "since birth" or "in infancy" were common in case histories. There was no significant sex distribution. Nearly 50 percent of the reported cases were associated with cutaneous hemangiomas,<sup>3</sup> a phenomenon which was lacking in our patient. The finding of cutaneous hemangiomas in an infant who presents with intestinal obstruction or bleeding should alert the physician to this diagnostic possibility. The mortality of intestinal hemangioma with intussusception is nearly 30 percent.

Our case emphasized two salient points. The first is the extremely young age of the patient whose symptoms began at eight weeks, and the



second is the extremely rapid demise, 20 hours after the onset of minimal symptoms. Such a rapid course prevented the institution of surgical treatment to abort the fatal hemorrhage and intestinal obstruction which ensued.

## Bibliography

1. Gentry RW, Dockerty MB, and Clagett DT: Vascular malformations and vascular tumors of the gastrointestinal tract. *Int Abs Surg* 88:281, 1949.
2. Nader Philip R and Margolin, Frederick: Hemangioma causing gastrointestinal bleeding. *Amer J Dis Child* 3:215, 1966.
3. Silverman A, Roy CC, Cozett FJ: *Pediatric Gastroenterology*, St. Louis, Mosby 1971.
4. Hyun BH, Palumbo VN, Jull RH: Hemangioma of the small intestine with gastrointestinal bleeding. *JAMA* 208:1903-1905, 1969.

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## Pediatric Briefs

### Magnesium Therapy in Neonatal Tetany. Turner, T. L. *et al.*: *Lancet* 1:283 (1977)

One hundred infants with symptomatic late (greater than 4 days of age) hypocalcemia were treated with either phenobarbital, calcium gluconate, or magnesium sulfate (0.2 ml/kg of a 50% solution, 1M, twice, at 12 hour intervals). The magnesium sulfate treated group did far better than either other group both in terms of convulsions and in rapidity of return of calcium to normal.

Comment: The neonatal hypocalcemia due to mild transient hypoparathyroidism and high phosphate formulas seems to respond well to magnesium sulfate. Magnesium appears to mobilize calcium and stimulate parathormone production. It may, therefore, be the treatment of choice in late hypocalcemia "whether or not hypomagnesemia is present". R.H.R.

### Bronchiolitis and Asthma: Possible Common Pathogenic Pathways. McIntosh, L.: *J All Clin Imm* 57:595 (1976)

Bronchiolitis is usually a viral disease. Many children who get over bronchiolitis have other episodes of wheezing, often in association with other viral infections. Children who get Respiratory Syncytial Virus (RSV) infections without wheezing are less likely to wheeze subsequently. Children who get bronchiolitis from parainfluenzae viruses will more likely wheeze subsequently than those who get bronchiolitis from RSV.

Comment: This review summarizes current knowledge of bronchiolitis' relationship to asthma. More questions than answers are provided. The previous work of Polmar [*Peds* 50:279 (1972)] suggests that a method of differentiation may be the determination of IgE levels. This, however, does not help clarify the common clinical observation that some children (30-50%) who have classical "viral" bronchiolitis have recurrences which seem more and more allergic. R.H.R.

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Excerpts from CMDNJ-Rutgers Medical School *Pediatric Newsletter* (Vol. 1, No. 5, March 1977), Richard H. Rapkin, M.D. Editor. Dr. Rapkin has given *The Journal* permission to reprint this material from time to time.

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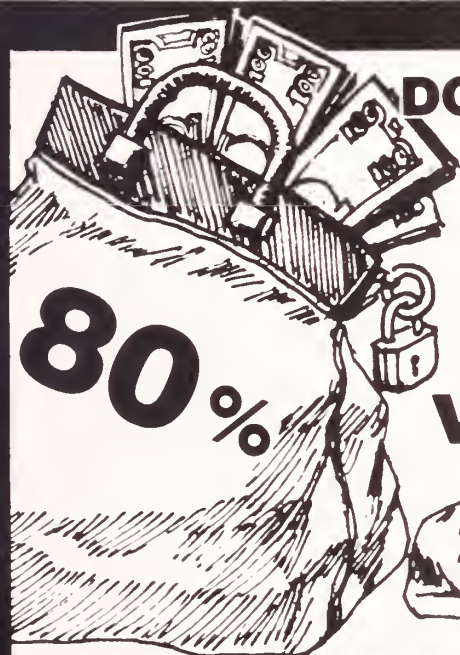
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*A telephone survey of Middlesex County, New Jersey disclosed significant attitudes toward medical care and health education. Nearly half the respondents complained about excessive waiting before they actually saw medical personnel in offices, clinics, or emergency rooms. The majority had no complaints about the type or quality of care once they reached the physician. Three-quarters of them would turn to a physician to answer a health question, although many respondents under 40 would first consult reference books. Four-fifths of respondents desired more health education from the mass media. The print media were regarded as the most convenient means of obtaining health information by 42 percent but TV was preferred by 22 percent. Surprisingly, a single Public Broadcasting System station (Channel 13) from New York City outpolled (60 to 36.5 percent) all of the other TV stations (three national networks and the New Jersey PBS system) when the question was: "Which TV health education reaches you?" A considerable number (33.5 percent) volunteered the suggestion that schools should provide more health education also. Many respondents wanted more information about emergency measures, resuscitation techniques, hypertension, cancer, heart diseases, and childhood diseases.*

## Public Opinion about Medical Care and Health Education\*

G. Paegle, J. Aumente, A. Isbit, Ph.D. and R. Paegle, M.D., Navesink

What do consumers think of health-care providers? We should know because consumer voices have been less audible in the debate about health-care quality than the politicians, news-media, and other interest groups. Therefore, we concentrated on the public at large.

Disease patterns also are changing, with chronic diseases and geriatric problems becoming more prominent. In addition, education of patients is needed to impress them with the importance of behavior and environment factors in epidemiology and etiology of disease<sup>1</sup>. For example, physicians enter the picture at the end-stage of cardiovascular disease, when a heart attack or a stroke has dropped a patient in his tracks. Only the public can change its own dietary and social habits in order to decrease the incidence and severity of arteriosclerotic heart disease. Dietary and social habits play key roles in many of the important diseases afflicting our population, prompting many health-care systems to adopt the concept of "partnership for health."

However, for such a partnership to succeed, it requires greater education on the part of the patient-partner. Therefore, eliciting public opinion about health care education and the role our news media have played and could play in the future for providing health care information was another goal of this survey.

### Methods and Results

Middlesex County has a mixture of population from such standpoints as economics, education, social scale, ethnicity, and urban-suburban backgrounds. Random selection of telephone numbers from the current local directory (one number from each page) permitted access to all areas listed in the directory. We dialed 436 numbers. Where the number called did not answer the first time, the number was tried at least three different times, on different days and at different times of the day. Fifty-two percent answered the telephone survey. Each family consisted of an average of 4.4 persons. The sex ratio of respondents was 73:27, female:male. Half were under 40, a datum elicited by asking, "Do you belong to the under-or-over 40 age group?"

**Question 1: If you needed an answer to a health question, whom would you ask?**

**Answers:** Doctor: 74%; Nurse: 2%; Family Member: 5.5%; Other: 15%; No Opinion: 3.5%.

Differences showed up between those over 40 and those

\*Presented in part at the 6th Annual Conference of the Health Education Media Association, April 22-25, Miami, Florida. Mrs. Paegle is research associate at the Education Federation, Navesink, New Jersey; Mr. Aumente is Chairman, Department of Journalism and Urban Communications, and Director, Urban Communications and Research Center, Rutgers University; Dr. Isbit is a staff writer for Rutgers University News Service; Dr. Paegle is Former Chairman of the Program Committee of the Middlesex County Medical Society.

under 40. More of the older (81 percent) would turn to a doctor than would the younger (66 percent). Of the younger, 18 percent would turn to reference books first, and contact a physician only if the situation became worse or it was a question of a serious illness. Another 10 percent of the younger group would turn to another family member first. Only 7 percent of the older individuals would turn to reference books, and less than one percent would turn to another family member.

**Question 2: What means of health education do you find most convenient?**

*Answers:* Newspapers and Magazines: 45%; Television: 23.5%; Lectures at hospitals or schools: 17%; Other: 6.5%; Pamphlets: 6.5%; Hot line: 3%.

**Question 3: Which TV health education information reaches you?**

*Answers:* WNET (PBS Channel 13): 60%; National networks (NBC, CBS, ABC): 27.5%; New Jersey PBS (Channels 50 and 52): 7%.

**Question 4: Should TV, radio and newspapers do more in health education?**

*Answers:* Yes: 80%; No: 14.5%; No Opinion: 5.5%.

**Question 5: Do you have any suggestions on how to improve health education?**

*Answers:* One-third (33 percent) of the respondents favored a greater role for public schools in health education. Greater educational effort by physicians was the preference of 17 percent. Another 14.5 percent wanted adult education programs run by hospitals or townships. "Don't know" was the answer for 29.5 percent. More clinic and outpatient education centers were urged by 2.5 percent.

**Question 6: What health care topics would you like to know more about?**

*Answers:* Most respondents did not have answers ready. When the interviewer read a list of possibilities, respondents selected from among them. The descending order of preferences was: Emergency medicine and resuscitation techniques: 39%; cancer: 17%; hypertension: 15.5% all on the list; 16.5%; heart disease: 14%; diabetes: 10%; childhood diseases: 5.5%. Each of the following was the choice of less than 3%: accidents, mental health, venereal disease, addict recognition, birth defects, learning disabilities, dangers of food and drug additives, physical fitness, headache, menopause, common cold, and problems of the handicapped.

**Question 7: Reporters have criticized doctors. Hospital and malpractice insurance costs keep going up. What do you think about this?**

*Answers:* A peculiar combination of responses were elicited. Many people dissatisfied with the overall situation had no complaints about their own physicians. Percentages for each kind of reply were as follows: High malpractice costs are the fault of litigious patients and/or attorneys: 16%; "no comment" or "don't know": 22%; physicians' fault: 12%; insurance underwriters' fault: 10.5%.

The respondents were full of barbed comments about the various targets of their anger. Among the targets they

selected: people in general, lawyers, "quick-buck" hunger, American Medical Association, greed, physicians, bill-padding, Medicare, Medicaid, medical-education costs, loss of contact between physicians and patients, health insurance, insurance underwriters, need for clinics for middle-class patients, hospital expansion, government, hospital overhead and mismanagement.

The comments included:

"It's so easy to start a suit today."

"Too much greed. Settlements are far in excess of what they should be."

"Doctors are paying more to get an education."

"Doctors lost contact with patients. Too money conscious."

"No objection to cost if care is good."

"Insurance companies are a racket. They promise to cover a lot, but when you get sick, you realize they don't cover half of anything."

"Have no complaints. Being treated for cancer at present."

**Question 8: Have you or any of your friends had problems with doctors or clinics recently? If so, about what?**

*Answers:* A large majority of the respondents initially denied having any problems or knowledge of others who had complaints about the care they had received from their doctors. Some expressed compliments about their doctors as well as their staffs. A variety of problems cited included: difficulties in selection of a physician in a new community, dunning by psychiatrist for past-due bill, charge for office visit to learn that nothing's wrong, reluctance of physician to respond to need for specialist, physician negligence, overspecialization by physicians, medication overdose, physician haste, and refusal to treat because Medicare pays too little. The comments included the following:

"It takes a long time to find a good doctor when moving to a new area. I had to interview several before I found one."

"Charging you \$20 to tell you everything is OK isn't fair."

"A friend of ours has heart trouble and may have a brain tumor. She can't find a doctor to treat her. About a dozen have refused because she is on Medicare."

"Doctors are too specialized. You could have a heart attack in a gynecologist's office and he wouldn't do anything because it's not his specialty."

**Question 9: Have you had to wait in doctors offices?**

*Answers:* Yes: 48%; No: 33%; No comment: 19%.

Many of those who complained about excessive waiting periods otherwise had no complaints about their health care or were even complimentary about it. The negative comments included:

"I had to change doctors even though I liked my old one. The note on his door 'You could be the emergency,' wore thin after prolonged, up to 3-hour waits in his office. I'm not

satisfied with my new doctor but at least I don't have to wait."

"If a doctor can't see me at the appointed time, he should pay me for waiting."

"I switched doctors after waiting at an office for 5 hours."

"If he knows he can't see a patient in 15 minutes, why schedule appointments like this? But the doctor does not care—he'll get his \$25-35. No one pays you."

"Doctors' fault, because they conduct their personal business in their office, like chatting with drug salesmen and insurance agents while patient waits."

"Doctors' fault. He controls the use of his staff. The problem is he's money mad."

"Doctors at fault. Should charge them because I had to wait 3-4 hours."

"Doctors take too many patients."

"Terrible! Awful waiting! I can see a reason for it in a baby doctor's office but not in a regular one. Doctors at fault."

"Terrible. I guess there are a lot of sick people."

"Not enough doctors."

"No, because I have learned to beat the system. I make mine the first appointment."

## Discussion

The diversity of the population in the surveyed county makes it more likely that the responses also represent, in broad outlines, the opinions encountered elsewhere in the state as well as in the United States. This assumption is bolstered by the fact that our results regarding the overall public trust in physicians' performance and reliability are in accord with the high marks given physicians for honesty and ethical standards as well as the public's confidence in physicians' organizations revealed by nationwide Gallup polls<sup>2</sup>. Consequently, we are confident that the information gathered here has a heightened validity wherever questions of attitudes of consumers toward health care become the subject of discussion.

Significant, first of all, is the emphasis of respondents on the physician's, clinic's or emergency room's waiting areas. Waiting and crowding were common irritants to patients, even if the majority were satisfied with the care they finally received. This is a significant factor in planning medical-care delivery, and one to be

given greater importance by facility planners, physicians, and others. The intensity of the response was not anticipated, hence the questionnaire had no provisions for quantifying the actual time spent in waiting rooms. In view of the implications of the responses, further studies seem indicated.

Waiting must be considered as a prime factor in complaints about physicians' fees. The United States has the most "time-is-money" and efficiency-oriented society in the world. Drive-ins, speed check-out counters, computerized scheduling, and a plethora of other practices all are geared to cutting down waiting. To be forced to wait at a time when one is in pain or one's health and/or happiness seems in jeopardy may be doubly infuriating. Hence, it should not be surprising that the irritated patient observes, while waiting, other activities considered to be inefficient use of time or facilities and builds a resentment. For example, the patient may count up the number of waiting patients, multiply by the amount charged for one visit and arrive at an exaggerated estimate of doctor's earnings. Some of the comments about doctors earning too much may have stemmed from such resentments. It's also possible that resentment built up during waiting periods contributes to malpractice litigation later. Review of case histories may reveal excessive waiting as a contributing factor.

Some of the respondents realized that physicians also may have legitimate complaints about patients showing up late and failing to understand that real emergencies may pull the physician away from the office.

Although improved scheduling may be in order, perhaps physicians and hospital emergency rooms also might take advantage of the public's wish for health education and put the waiting patients to work, i.e., provide material for them to study. Distribution of printed materials and display of audiovisual programs also will allow the patients to become more knowledgeable and more cooperative patients.<sup>3</sup> Addition, in the waiting rooms, of videotape units with earphones will allow even greater diversity of materials for education of the health consumer.



One interesting aspect of health education is the opportunity to counteract adverse consumer attitudes. Fears on the part of medical professionals that publicizing consumer attitudes might do more harm than good<sup>4</sup> are not justified, on the basis of the information gathered in this and in a previous survey<sup>5</sup>. The public accepts medical care as currently available, so that surveys ought not be kept hidden for fear of arousing latent hostility.

In regard to question 2 most respondents appeared to use the word "convenient" in the sense of "easy to use" rather than "which do you learn from most?" In response to question 3 the respondents indicated specific channels which they had watched for health education. No attempt was made by the interviewer to determine whether the preferences were based on current shows or whether past programs may have been included.

Most people did not equate health education with sex education, hence the urging for public schools to do more (Question 5) should not be misinterpreted.

The answers to question 5 that there should be more clinic and outpatient education centers may be a response to the pioneering efforts by the area hospitals and the Office of the Consumer Health Education on the campus of Rutgers Medical School, a division of the College of Medicine and Dentistry of New Jersey<sup>6</sup>. This explanation seems likely since these responses were volunteered and not suggested by a listing provided by the interviewer and we are not aware of any news media campaign to promote such a solution.

Most respondents did not confuse medical drama shows on TV with real health education. Also, the variety of critical responses to question 7 confirms that consumers, as a group, have not been swayed as a unit by any pressure group or any single sensational news media story or even series. This suggests that it would be valuable to solicit advice from consumers in preparing new policies or regulatory measures. If free medical care swamped clinics, causing crowding and waiting, lawmakers might find

the public thankless and full of blame, instead of praising a move toward reasonably priced medical care.

Patients unable to be treated because physicians reject Medicare cases may go through considerable emotional trauma. Refusal to treat cannot help but intensify the emotional impact of being ill. Physicians could assist by referring to another physician, instead of merely rejecting the patient. It's easier for physicians to know which other colleagues accept such patients than it is for the patient to find out for him/herself. This is where a directory of physicians, prepared by the county medical society, could help identify physicians who cooperate with Medicare.

The power of the news media to alter the awareness and interest in different health care topics was evident in the county we studied. A preliminary survey<sup>5</sup> eight months earlier indicated that information about cancer detection and heart disease had been at the top of the list (30.8 and 21.4 percent) respectively. Emergency care at that time had received only 3.7 percent of the preferences. Following that, the news media carried repeated stories about CPR and the Heimlich procedure. This pushed public awareness and concern about these measures to the top of the list (Question 5). In addition, some respondents had taken action, i.e., taken CPR training. Others were complaining that there were not enough courses to satisfy the demand—they had met with overbooked courses.

Health care providers now must consider how willing they are to share health care education with their junior partners, the patients. Refusal to provide more education may arouse resentment and clamor for more federal controls and/or participation. In addition, news media may have to review their commitment of writers, space, and funds for venturing into the health education area, which has different ground rules from spot news reporting.

Some news media, including major newspapers and TV stations have put physicians on their programs or as staff writers<sup>7</sup>. Growth of such

cooperation between physicians and the news media should lead to a healthier as well as happier public—patients as well as readers and viewers.

## References

1. Dorsey DB: Future directions in health care. *Pathologist* 31:175, 201, 1977.
2. Gallup Organization Inc: Gallup study of communications credibility, August and December, 1976. AMA Status Report, OF:196-N: 4/77:597M:#6.
3. Lazes P: Health education project guides out-patients to active self care. *Hospitals* 51:81-86, 1977.
4. Bronstein MR and Bruno MA: Most people have no complaints against physicians. Middlesex County *Med Soc Bull* 42:15, 1976.
5. Niemiera RM: Public opinion of medical care in Middlesex County: Preliminary report. Middlesex County *Med Soc Bull* 42:16-17, 1976.
6. Somers AR: Consumer health education—to know or to die. *Hospitals* 50:52-56, 1976.
7. Goldberg M: A doctor examines TV's health shows. *TV Guide* 25:4-8, 1977.

P.O. Box 100, Navesink, New Jersey



**Navesink River** (Monmouth County, NJ). Summer 1977. Original photograph courtesy of John L. Krause, Jr., M.D., plastic surgeon, Cherry Hill, a member of our Camden County Medical Society. Dr. Krause is an accomplished medical and nature photographer, as well as a lecturer on these subjects.

# *Lifesaving Partnership... Against Cancer Quackery*

The anguish associated with cancer is compounded by the cancer quack. False hopes—harmful delays—devastating expenses—deceptive diagnoses—loss of life—these are hazards facing the cancer patient desperate enough to seek a cancer quack.

*The problem:* how to divert the patient from this tragic encounter.

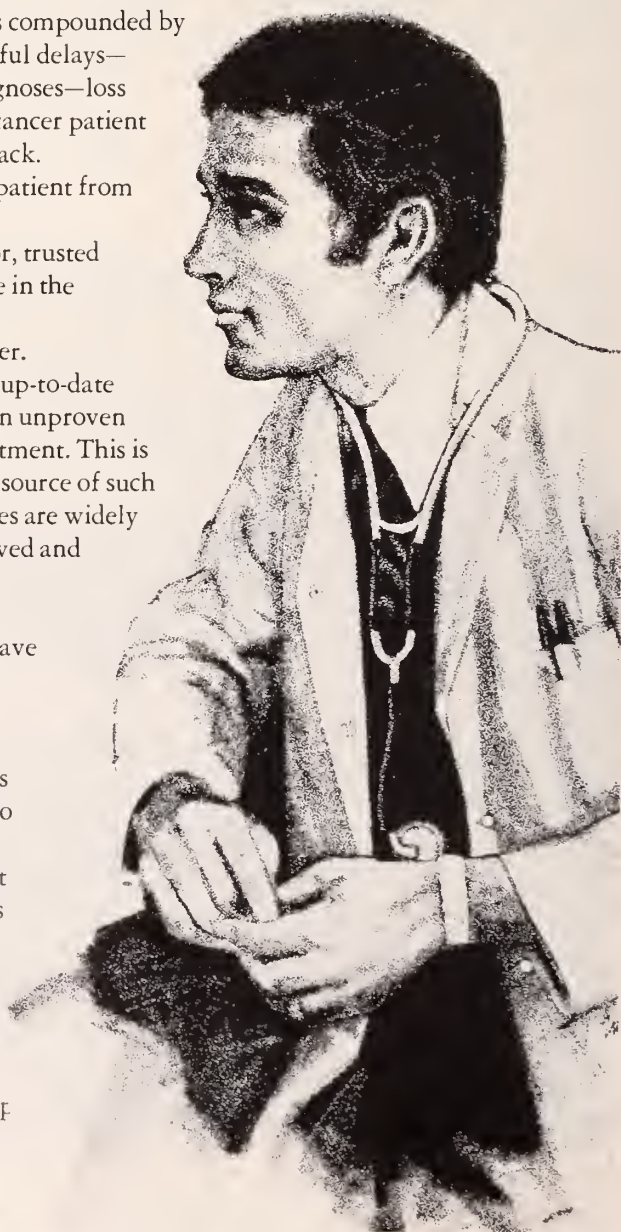
As medical guide, family counselor, trusted friend—you, *doctor*, play a major role in the fight against cancer quackery.

We are here to serve as your partner.

Our National Office maintains an up-to-date central clearinghouse for materials on unproven methods of cancer diagnosis and treatment. This is a unique operation and the principal source of such information in the country. Its services are widely used. Hundreds of inquiries are received and answered from all segments of the community, from coast to coast.

To trigger grass-roots action, we have formulated a model State Cancer Remedy Act designed to control the promotion and sale of unproven methods of cancer management. This has helped to inspire some 20 states to enact or consider legislation against cancer quackery—with active support from the medical community. Copies of the model act, as well as copies of laws in effect, are available through our National and Division offices.

In these actions against cancer quackery, as in all our efforts against cancer, ours is a lifesaving partnership



*American Cancer Society* ☸



### A View of the British National Health Service in 1977

This writer visited Great Britain for two weeks in July, 1977, and had the opportunity to gain a first-hand picture of the British National Health Service (NHS). During that period, the British Medical Association (BMA) was meeting in Glasgow, Scotland to plan a strategy to combat the steadfast refusal of the Secretary of State for Social Services to increase the pay scale for physicians as well as to correct many other injustices and problems. The daily London newspapers were filled with headlined articles featuring the BMA views, the relevant debates in Commons, the statements of the Health Chancellor, editorials, and letters to the editors.

The BMA Committee, representing 11,000 hospital consultants (specialists) rejected the government's pay policy and called for a one-day national strike in the fall of this year. Mr. Ennals, Secretary of State for Social Services "described the strike call as deplorable and pointless" and "said there would be no further pay raises for doctors before next April" (1978).

#### Background

At The Royal Society of Medicine, founded in London in 1805 and recognized in 1834 when it received a Charter of Incorporation from King William IV, a lecture entitled "Organisation of Medical Care in the U.K." was presented to our small group of visiting physicians from the United States by Dr. Robert M. Shaw, former Deputy Chief Medical Officer of the Department of Health and Social Security. Dr. Shaw was involved with the development, implementation, and operation of the NHS from its inception until his recent retirement.

Shaw described the origins of the present system with the passage of the National Health Insurance Act (NHI) in 1912. This legislation provided the workers with outpatient primary care, based on contributions by the employer and the employee. At that time, the general practitioner had a panel of patients and was paid by a capitation fee. Hospital care then was provided in the non-profit voluntary hospitals

(Guy's, St. Bartholomew's, St. Thomas') where care was free or based on a "means test," or in Nursing Homes, which were small private hospitals. The medical staff gave its services free to the voluntary hospital and made a living from private practice.

In the 1930's the government opened municipal hospitals in the larger towns and provided free care through the services of a paid hospital medical staff. Two World Wars and 34 years after the NHI Act, the National Health Service Act (NHS) was passed in 1946. In 1948, a tripartite medical system was initiated to provide "free comprehensive health services" for the entire population. The originators of the NHS believed that the provision of universal medical care would so improve the health of all citizens that the ultimate costs of the program would fall. The three elements were general practice services, Regional Hospital Boards (13 in England at that time) and Local Authority Services. Every patient was able to register with the GP of his choice, provided the doctor was willing to accept him. If accepted, the GP was required to provide care in the office and at home when necessary. The Regional Hospital Boards took over all the publicly-owned voluntary hospitals and began to provide medical specialty services to remote areas on referral of the GP. The Local Health Authority services included home health visitors, public health nursing services, ambulance service, and so on.

#### Physician Income

Salaries are determined by regional committees, but overall pay policy is set by the central government and the DHSS. At present, salaries are frozen.

The salary of the GP is computed on a basic practice allowance onto which is tacked a number of allowances and "percs." In the period 1975-1977, the basic practice allowance for a GP was £ 2575 (\$4609). To this is added a capitation allowance which varied with the first 100 patients, the next 900 patients, and the

age of the patients. A larger capitation is allowed for the elderly. Additional payment is provided for "seniority"—£ 580 (\$1038) for 13 years, £ 985 (\$1763) for 20 years, and £ 1,570 (\$2810) for 30 years' experience. Practice as a member of a group adds £ 420 (\$752) and practice in an area designated by the government adds £ 750 (\$1342) to 1,150 (\$2058) to the annual salary. "Percs" include small extra fees for immunization injections, night calls, cervical smears, family planning advice, insertion of intrauterine devices, and outpatient vasectomies. The occasional Health Center which is located at some distance from a chemist (pharmacy) is permitted to stock and dispense drugs. In this instance, the doctors may keep the 20 pence fee paid by each patient per prescription.

The bottom line, in terms of general practitioner income, is striking. The net annual practice income (after taxes) for GP's in 1975-1977 was £ 6336 (\$11,341). This should be related to the fact that income taxes for this group would be 35 to 40 percent.

The practice income for consultants (specialists) is based on a different system. The basic range of salary was £ 7,536 (\$13,489) to 10,689 (\$19,133) in 1976. To this can be added increments based on "awards." Consultants receive "awards" when selected by a peer-review system based on the quality of work, teaching, published books and articles, research, and so on. One in three consultants has received awards; which are described in the following table:

<i>Award</i>	<i>Salary Increment</i>	<i>Number of Consultant Recipients</i>
A Plus	10,689 (\$19,133)	130
A	8,109 (\$14,515)	487
B	4,761 (\$8,522)	1,390
C	2,025 (\$3,625)	3,135

Below the consultant level, the salary ranges drop off as follows:

<i>Hospital Physicians</i>	<i>Annual Salary ( £ )</i>
Senior registrar	4,818-6,279 (\$8,624-11,239)
Registrar	4,152-5,109 (\$7,432- 9,145)
Senior house officer	3,663-4,152 (\$6,557- 7,432)
House officer	2,859-3,294 (\$5,117- 5,896)

It should be noted that registrars and senior registrars require eight years of study before being eligible to become consultants. It is also relevant that the shortage of house officers requires many to work overtime, for which they receive extra pay.

At present, consultants are permitted to supplement their income by admitting "private patients" to the hospital. These patients pay a fee to the surgeon or physician for services rendered in the hospital.

In 1974, Parliament reorganized the NHS and unified it so that all health services were brought under a single authority, the Department of Health and Social Security (DHSS). With this bureaucratic expansion, Regional Health Authorities (RHA), Area Health Authorities (AHA) (divisions of RHA), and various local committees were formed. The plan envisioned District General Hospitals, Community Hospitals, and Community Health Centers, which have been slow in development for financial reasons. Some of these hospitals are under construction, while others are being planned; the same is true of the Community Health Centers, which most resemble our neighborhood health centers. In 1965, there were only 28 Health Centers, served by 215 GP's; in 1975 there were 634 Health Centers with 3,474 GP's.

### Costs of NHS

The costs of NHS to the United Kingdom are seen in the following table:

<i>Fiscal Year</i>	<i>Million Pounds*</i>
1948-1949	247
1958-1959	671
1968-1969	1513
1976-1977	5001

The spectacular rise in costs was not due to inflation nor to the cost of the services of general practitioners, but to the tremendous increase in hospital-bed utilization. The number of beds in 1949 was 212,000 and bed utilization was 2.8 million patients; by 1971 the

\*At the time of this lecture the exchange rate was \$1.79 for one pound ( £ )

number of beds was reduced to 204,000, but occupancy rose to 5.1 million patients. In 1974, health costs consumed 11.5 percent of the entire United Kingdom budget. These figures must relate to the fact that the population of England is 60 million.

The sources of money to pay the national health bill in 1976-1977 were as follows:

<i>Source</i>	<i>Million Pounds</i>	<i>Percent</i>
Central government	4,366	87.3
NHS contributions	512	10.2
Charges to patients	109	2.2
Miscellaneous	14	0.3

Patients pay 20 pence (approximately 36 cents) per prescription and also pay part of the costs of dental treatment, dentures, eyeglasses, and so on. It recently has been suggested that a "hotel charge" be imposed on all hospitalized patients, but that has not been initiated to date.

**Hospital Bed Utilization**

There has been a striking increase in hospital-bed utilization in the United Kingdom primarily because of scientific advancements, changes in therapeutic approaches, and confidence of the patients in hospital care, which is uniformly supervised by specialists. As noted above, in the two decades following the start of the NHS, the number of patients occupying hospital beds has doubled. Some bits of evidence relating to this phenomenon can be mentioned. While the number of hospital discharges after abortion rose by ten percent from 1961 to 1967, the number of therapeutic abortions increased by a factor of five times; septic abortions decreased during that period. The explanation was an increasing demand for

therapeutic abortion, which culminated in the Abortion Act of 1967.

Although only six percent of patients with chronic bronchitis seen by general practitioners in England and Wales were admitted to the hospital, they remained 25 to 28 days and continuously occupied 5,000 to 5,500 beds. As tuberculosis, polio, and other infectious diseases required fewer beds, cancer progress in diagnosis, treatment, and research led to greater bed utilization. Transplant surgery, renal dialysis, intensive care units, cardiovascular surgery, computerized scanning, and other advances added their effects.

Patients are admitted to hospitals by one of two methods: referral from the GP to the consultant who arranges the admission, or admission of a patient through the accident and emergency department of the hospital.

Delays in elective admission to the hospital through NHS have become a major source of aggravation to the public at large, to patients, to the unions, and to physicians, especially general practitioners. Elective surgery entails a wait of up to a year or longer, while stroke patients are infrequently admitted and other non-emergent conditions such as breast lumps, angina pectoris, and bronchitis require weeks to months for admission. There is no delay at present for admission of self-pay patients for surgery. NHS hospitals charge as much as \$100 per day for private beds. A. Krosnick, M.D.

Further commentary on the BNHS in the areas of general practice, voluntary health agencies, and private practice will appear in the October issue JMSNJ.

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**Dosage and Administration:** Oral: 10 to 20 mg., three or four times daily.

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**Supplied:** Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose; Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose; Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls

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# NEW JERSEY DOCTORS' NOTEBOOK

## Trustees' Minutes

July 17, 1977

A regular meeting of the Board of Trustees was held on Sunday, July 17, 1977, at the Executive Offices, Trenton. Detailed minutes are on file with the secretary of your county medical society. A summary of significant actions follows:

*Joseph P. Donnelly, M.D.* . . . Directed that the Executive Committee arrange for an appropriate gift for Joseph P. Donnelly, M.D., in recognition of his distinctive service as a Delegate to the AMA for 15 years, 12 of which he served as chairman of the New Jersey Delegation.

. . . Directed that a contribution be made to MSNJ's Medical Student Loan Fund in honor of Dr. Donnelly.

*Physician Consulting Team* . . . Approved a list of names (with minor changes) developed by the State Department of Health for appointment to the Physician Consulting Team to assist in the diagnosis-related group concept.

*Commissioner of Health's Medical Advisory Committee* . . . Authorized the Executive Committee to appoint five to seven Trustees to the Commissioner of Health's Medical Advisory Committee which also will be concerned with the diagnosis-related group concept. This will involve weekly meetings in September or October and a \$150 per diem is authorized.

*Advisory Committee, Physician's Assistant Program—CMDNJ* . . . Approved the selection of Dr. Arthur Krosnick for appointment, in a voting capacity, to the Advisory Committee, Physician's Assistant Program—CMDNJ, Rutgers.

*Note:* Rutgers Medical School understands that such appointment does not indicate endorsement and has given written assurance that it will not make political use of such appointment.

*MSNJ Student Association* . . . Approved the formation of the Medical Society of New Jersey Student Association and authorized the use of the seal of the Society on the Association's stationery and newsletter, *The Innominate*.

*MSP Coverage of Fees for Surgical Assistants* . . . Referred the following recommendation from the Judicial Council to the Council on Medical Services and suggested that Dr. Charles L. Cunniff of MSP be invited to attend the Council meeting when this item is discussed:

That the Board of Trustees, either itself or by referral to the appropriate council or committee, negotiate with MSP for realistic coverage of assisting surgical fees in major elective procedures.

*Associate—Intern and/or Resident—Members* . . . Approved the following ruling of the Committee on Credentials governing advancement of interns and/or residents from associate to regular membership.

Upon receiving licensure to practice medicine and surgery in New Jersey a physician previously elected to associate membership (intern and/or resident) must submit a new application to the State Society Committee on Credentials for approval before elevation to regular, active membership.

*Citizenship Requirement for Membership* . . . Disapproved a recommendation from the Committee on Credentials that citizenship or the filing of a formal declaration of intent be reinstated as a requirement of membership in MSNJ.

*MSNJ Department of Liability Control* . . . Received as informative a detailed written report from Dr. James E. George, Director of MSNJ's Department of Liability Control, on the recent activities of that Department—copy is on file in the Executive Offices.

*AMA Annual Convention* . . . Received as informative a detailed written report from Dr. Frank J. Hughes, Chairman of the New Jersey Delegation to the AMA, on recent actions taken by the AMA House of Delegates—copy is on file in the Executive Offices.

*CAT Scanners* . . . Accepted the opinion of the Council on Medical Services that the Blue Cross/Blue Shield fee schedule for CAT scanners has been revised so as to offer equal reimbursement to hospitals and to private physicians.

*Note:* In 1975 Blue Cross/Blue Shield had initiated a pilot program for CAT scanner fees which resulted in a differential in the fees to hospitals and to private physicians. The program has been discontinued and the Council on Medical Services is satisfied, after thorough investigation, that there is now equal reimbursement.

*Committee on Nutrition—New York Academy of Medicine* . . . Approved a recommendation from the Council on Medical Services that the Board of Trustees appoint Dr. Howard N. Jacobson (Chairman of the Ad Hoc Committee on Nutrition) as official representative of MSNJ on the Subcommittee on Nutrition of the Committee on Public Health of the New York Academy of Medicine.

*Payment for Automated Tests Under Medicare* . . . Noted and filed a recommendation from the Council on Medical Services for acceptance of changes in payment for certain blood chemistry tests under the Medicare program, as submitted by Prudential Insurance Company of America, since it is not within the purview of MSNJ to approve or disapprove fee schedules under the Medicare program.

*Revision of Rider J Laboratory Fee Schedule* . . . Noted and filed a recommendation from the Council on Medical Services for acceptance of revisions by Blue Cross/Blue Shield of the New Jersey laboratory fee schedule, since it is not within the purview of MSNJ to approve or disapprove fee schedules relating to MSP coverage.

*"Model Health Care System"* . . . Directed that a copy of a letter from Dr. Daniel J. O'Regan, Medical Director of the New Jersey Foundation for Health Care Evaluation, with its enclosed report of the Committee on Alternative Health Care Systems of the New Jersey State Department of Health, dealing with a "Model Health Care System," a copy of the remarks made at the recent AMA annual meeting by Secretary of HEW Califano, and a

letter from the President of MSNJ, indicating the Society's opposition to the "Model Health Care System," be sent to the AMA, the county societies, and the specialty societies.

. . . Directed further that the President and the Chairman of the Board of Trustees appoint a task force to work with the AMA and other interested societies to:

- (1) study and find ways to see what can be done to circumvent the implementation of the "Model Health Care System" as proposed
- (2) prepare a critical analysis (using a positive approach) of the content of the Committee's report
- (3) write a position paper showing what the Society sanctions.

*Search Committee for Key State Cabinet Position* . . . Approved a report of the Search Committee for Key State Cabinet Positions—copy is on file in the Executive Offices.

*AMA Seminar on British National Health Service* . . . Received as informative a detailed written report from Dr. August L. Baker, MSNJ representative at the AMA Seminar on the British National Health Service, held May 23-27 in London—copy is on file in the Executive Offices.

*Public Relations Status Report* . . . Received a status report from the advertising firm of Paolin and Sweeney concerning its activities in the areas of television, newspapers, magazines, and a debate between major gubernatorial candidates. It was noted that the Society's antismoking commercial won highest honors in the Annual Philadelphia Television and Radio Club Awards.

*Temporary Licenses* . . . Tabled further consideration of the question of temporary licensure to practice medicine until the Board of Medical Examiners is reconstituted.

*Note:* The New Jersey State Board of Medical Examiners, at its June 8th meeting, reaffirmed its previous position of opposition to temporary licensure of physicians to practice medicine and surgery in the State of New Jersey.

*PSRO Liaison* . . . Deferred action on a request from Dr. William A. Dwyer, Jr., that the Board



of Trustees create a special committee to deal with PSRO matters until Dr. Lang (NJFHCE Trustee and Executive Committee member) can discuss the request with Dr. Dwyer.

*MSNJ Computer Use* . . . Noted, in response to an inquiry from Dr. Bernstein as to use of the MIIE computer system for physician recognition awards, that the MIIE computer system would not be available for use by MSNJ until spring of 1978.

*Practice Related Educational Program (PREP)* . . . Voted to endorse PREP for use by members of the Medical Society of New Jersey.

*Note:* PREP is a new system in continuing medical education, developed by the College of Physicians of Philadelphia with cooperation of the National Board of Medical Examiners, based on the premise that the busy physician requires a program that will specifically address itself to his or her practice. It is approved for Category I credit in the AMA Physician's Recognition Award.

*Council of State Committees on CME* . . . Voted to join and financially support the Council of State Committees on Continuing Medical Education, whose purpose is to promote communication between the states, to relate CME, at the state level, to the needs of the physician, to maintain the function of the state medical societies as survey and accrediting bodies for groups offering CME within the state, and to participate with such organizations as may be deemed appropriate in the formation of policies concerning CME.

. . . Directed that Dr. James A. Rogers be nominated for membership on the Liaison Committee on Continuing Medical Education.

*Quality of Life Conference* . . . Directed that a request from Dr. John Harrigan (Hahnemann Medical College) concerning suggestions for and/or participation by MSNJ in a state-wide Quality of Life Conference be referred to Dr. Howard N. Jacobson.

*Tel-Med Tapes* . . . Authorized the Council on Public Relations to cooperate with the New Jersey Hospital Association in the review of tapes for the "Tel-Med" program, a program which provides general health information to the public by means of pre-recorded tapes accessible via the telephone.

*Health Care Administration Board Regulation* . . . Empowered the Executive Committee, in consultation with the Radiological Society of New Jersey and the New Jersey Hospital Association, to develop a position paper in response to the following regulation adopted by the Health Care Administration Board:

"In addition, an application facility must document all remuneration and charges for its professional component. Professionals shall be required to have a contract with a facility and all professional contracts must be filed with the documentation."

*County and Specialty Society Relations* . . . Authorized MSNJ's staff to implement a suggestion of Board Chairman Todd that communication be made with the county and specialty societies urging them to request the assignment of a Trustee to attend one of their meetings for the purpose of promoting greater understanding and rapport between these organizations and the physicians they represent.

## 212th Annual Meeting May 6-9

*Headquarters Hotels*

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## CMDNJ Notes

Stanley S. Bergen, Jr., M.D.  
President, CMDNJ

*The College of Medicine and Dentistry of New Jersey reaches another milestone this month with the inauguration of its CMDNJ-New Jersey School of Osteopathic Medicine. I am turning over the space this month to the dean of the school, Benjamin L. Cohen, D.O., so that he can introduce his institution and its goals to the physician community of New Jersey.*

### The Reason for Being

*"You see things, and you say, 'Why?' but I see things that never were and I say 'Why not?' ..."* George Bernard Shaw.

Some of the questions most often posed to me by laymen and professionals alike are:

Why is there need for an osteopathic medical school?

What is different about osteopathy?

Since your training (osteopathic and allopathic) is now so much alike, why isn't there amalgamation into one unified profession?

The etiology of such inquiries is interesting and complex. Behind it is a combination of factors, including inadequate dissemination of factual material, early zealots' views (or misinterpretations) that manipulation would obviate all other treatment modalities, and the poor public relations, or lack thereof, that has been the traditional lot of osteopathic medicine.

However, the creation of a two-party system of medicine, concededly with some inherent difficulties, provided the consumer with an option for care. It remains today one of the viable strengths in health-care delivery and is, in itself, justification for continuation.

It has been 76 years since an M.D., Andrew Taylor Still, created a school of osteopathy (an unfortunate misnomer, meaning pathology of bone) "to improve our present system of surgery, obstetrics, and the treatment of disease generally, and place the same on a more rational basis, and to impart information to the medical profession."

Dr. Still hypothesized that the structure is a

determinant of function and that if one could maintain muscular-skeletal integrity, it would be a valuable aid to the maintenance of homeostasis. He further hypothesized that "the rule of the artery is supreme." Alluding to the fact that a specific organ function could be altered with a compromised blood supply, he suggested, therefore, that impaired organic function may be the consequence of a disturbance in the nerve innervation of blood vessels.

Holistic approach, therefore, was defined as total orientation toward man and his disease, rather than toward just the specific disease or organ component. One last tenet of Dr. Still's philosophy was that the body possessed humoral factors that were responsible for its healing itself. Let me respectfully remind you that these thoughts were promulgated at a time when classical medicine was prescribing purging, bleeding, leeches, and cow dung poultices. Immunological concepts of bursa and thymic cell competency were horizons never dreamed of. If nothing else, it was a time in which manipulation to correct structural malformations may have been as good as the proverbial apple to keep away the doctor with his bag of harmful medicines.

The golden age of medicine came into being in the past seven and a half decades, and with it the vast body of knowledge that is responsible for the sophisticated, technological volcano of activity that literally has changed the topography of disease. Simultaneously, it brought with it recognition that some of the lava the volcano spawned was harmful, and that the depth of the crater itself is unknown. Indeed, efficient methods for health care delivery never quite have matched the gusto of scientific development.

During these seven and a half decades, osteopathic medicine adopted the classical medical curriculum, while using basic holistic philosophy as the underpinning of its approach to the patient. Manipulation and muscular-skeletal diagnostic modalities were incorporated as additional armamentarium to augment the classical approach where indicated. The profession addressed itself to health-care delivery in rural and under-physician-populated areas.

Armed with a sense of acceptance, osteopathic medicine took up battle and successfully fought in legislative halls across the country for the right to take the same licensing examination as M.D.'s. The profession grew on mini dollars, provided vast primary services and became somewhat saprophytic to the mega-dollar allopathic institutions that were heavily endowed with research capabilities. Vermont became the first state to grant osteopathic licensure in 1896, but it took until 1973, when Mississippi acceded to full practice rights, that osteopathic physicians were accepted in all 50 states.

In 1970, JAMA reported that, on a percentage basis, twice as many United States medical graduates failed licensure examinations as did osteopathy graduates in states where one board administered the same examination to all applicants.

Somewhere within the two systems of medical practice lies a void, and it is to that point that the College of Medicine and Dentistry of New Jersey—New Jersey School of Osteopathic Medicine is addressing itself.

Each year, more than one million of New Jersey's 7.3 million citizens receive their medical care from osteopathic physicians, both in offices and in hospitals. Osteopathic physicians make up 7 percent of New Jersey's total physician population. Thus, 7 percent of the physicians attend to 14 percent of the population. It has been reported that 48 percent of the osteopathic population practices in the seven southern counties of the State.

The public commitment and legislative support of this service-oriented profession are neither unrealistic nor difficult to understand. They have produced an osteopathic medical school as part of CMDNJ's service to South Jersey. Similar experience in other states during the past several years has resulted in doubling the number of osteopathic schools since 1968. In addition to New Jersey, legislative enactment has created state-supported osteopathic medical schools in Ohio, Michigan, Oklahoma, Texas, West Virginia. On the drawing boards are schools in Florida, California, Arizona and Maine. In 1976-77, 3,655 students were enrolled

in the ten existing schools, with a total freshman class of 1,089. Two new schools will open their doors this fall.

The College of Medicine and Dentistry of New Jersey constitutes a unique setting for all major health disciplines to share their educational endeavors. With joint experiences, exchanges of scientific and educational information and ideas, and public and administrative scrutiny the College of Medicine and Dentistry now is able to present to the state of New Jersey a health-care educational institution that is totally comprehensive. The osteopathic profession welcomes this opportunity to participate in an arena where input is based on parity and the results are measured by like standards.

CMDNJ—New Jersey School of Osteopathic Medicine's inaugural class of 24 students begins its studies this month. There were nearly 16 applicants for each opening in the class; of the 24 successful applicants, 23 are residents of New Jersey. In their first two years, they will attend class at CMDNJ-Rutgers Medical School, Piscataway, where their basic sciences will be taught as a cooperative venture between the faculties of CMDNJ-Rutgers Medical School and CMDNJ-New Jersey School of Osteopathic Medicine. The clinical portion of the first two years will be taught by osteopathic physicians, and the students will be given courses in biomechanics. The last two years of the curriculum will be spent in a clinical setting in the Camden area. There, they will receive ambulatory and primary care training and rotations in a specialty and tertiary care at one or more affiliated osteopathic hospitals.

The School has a multi-purpose mission, with a primary goal of providing undergraduate osteopathic medical education. In addition, it will support ongoing basic science, clinical, medical and osteopathic research, graduate training at all levels in all specialties, continuing medical education, and community service. Historically, 70 percent of osteopathic physicians deliver primary care. It is hoped that this trend continues. The school also will be concerned with the total panorama of medicine and will participate in creating an academic environment for the training of tomorrow's educators and researchers.



Experience has dedicated a large allopathic training program throughout the country where osteopathic physicians have served as house officers. Thus the professions have met a challenge of cooperation. I am optimistic that our educational efforts will provide fertile ground for reasonable men and women of science and dedication to humanity to live in a milieu of mutual respect and support.

In theory, educators and scientists housed under one roof should establish a citadel of truth, where the only tradition encouraged is that of seeking new and different answers to old and recurrent problems. Territorial imperatives, prefactual judgments, and unrealistic worry about tarnishing the citadel's brass doors have no place in a society where the answers are still forthcoming. In the final analysis, the courage displayed by an educational system willing to respond to the need of its students speaks well for its architects.

Benjamin L. Cohen, D.O., Dean  
New Jersey School of Osteopathic Medicine  
CMDNJ

## Report from the Foundation

Daniel J. O'Regan, M.D., Medical Director

In July, the National Professional Standards Review Council considered the matter of continued federal funding of statewide support centers. The intention of DHEW had been to discontinue all direct funding as of October 1, 1977 (the starting date of the new fiscal year), and to permit subcontractual arrangements between PSROs and support centers, where PSROs desired such contracts, and where support centers have demonstrated their effectiveness. Your Medical Director was invited to address the National Council on July 18, on behalf of the eight remaining support centers. The Council recommended that direct federal funding be continued for an additional six months, through next March, at which time the Council again will consider the future role of support centers. Thus, we will continue until next spring. The subcontract route with the PSROs, and also with the State Professional Standards Review Council, when operable, continues. Long-term support center roles will depend, eventually, on the subcontract arrangements. It was a "feather" in the cap of your Foundation to be recognized by DHEW as well as the other support centers in this manner.

Interest in prepaid health care is increasing in New Jersey. Our HMO/IPA Committee has had several requests for advice on feasibility projects. In this regard, there appears to be some misunderstanding as to the direction of our interest in that area. The Foundation is pursuing the concept of the Individual Practice Association, or IPA. As outlined in this space previously, this model is closest to the traditional mode of practice, giving freedom of choice to physician and patient. We are not concerned primarily with the closed-panel HMO (Health Maintenance Organization) as a delivery system. It is necessary to discuss both methods in presentations, and this may have created some confusion. It is hoped that this note will make our position clear.

### **212th Annual Meeting**

**May 6-9**

**Headquarters Hotels:**

**Holiday Inn**

**Howard Johnson Regency**

**Atlantic City**

## Therapeutic Drug Information Center\*

### 1. Please provide information concerning disopyramide.

Disopyramide phosphate (Norpace®) is a new antiarrhythmic drug (chemically unrelated to other agents of this class) under investigation by Searle. It is active against atrial and ventricular arrhythmias. The agent is administered orally and appears to have few side effects.

Vismara, *et al.*<sup>1</sup> conducted a single blind placebo-controlled 16-week study in 18 outpatients having different kinds of ventricular and/or atrial arrhythmias. The efficacy of disopyramide phosphate (DP) was evaluated by serial ten-hour, portable electrocardiogram monitoring during placebo and active drug administration. Compared to placebo, DP resulted in a striking reduction in the frequency of all-ectopic depolarizations. Further, the prevalence of ventricular arrhythmias (ventricular tachycardia and ventricular ectopic depolarization) significantly decreased with DP. Atrial tachycardia, noted in six patients with placebo, was abolished in four during active drug treatment. The drug was well tolerated in five patients with cardiac decompensation prior to its administration. One patient was dropped from the study because of nausea and vomiting, and six others reported minor anticholinergic side effects.

Nichols and Willis<sup>2</sup> investigated the efficacy of DP for long-term treatment of ventricular arrhythmias. The study was conducted on 55 patients who had frequent ventricular beats or recurrent ventricular tachycardia. Forty-four of these patients had been refractory to other antiarrhythmic agents or had shown intolerance to them. After the first three months of DP treatment, there was 90 percent reduction of ventricular beats in 52 percent of the patients, and 64 percent of the patients had more than 50 percent reduction. This level of effectiveness was sustained for as long as 15 months. Ventricular tachycardia observed in 15 patients prior to DP therapy was abolished or reduced in nine patients. The major adverse effects observed were dry mouth and blurred vision. The authors concluded that DP is an effective and safe oral antiarrhythmic agent for long-term treatment of ventricular arrhythmias.

Jennings, *et al.*<sup>3</sup> compared (in a double-blind trial) the efficacy of oral DP with placebo in the prophylaxis of arrhythmias following myocardial infarction. Patients admitted to a cardiac care unit (CCU) with a presumptive diagnosis of acute myocardial infarction were randomly allocated to two groups. One group (46 patients) received DP in a dose of 100 mg four times a day, the other group (49 patients) received placebo. Both the groups were followed until their discharge from the CCU. The results showed that in the DP group there was a 50 percent reduction in the incidence of ventricular arrhythmias. There was also significant reduction in the incidence of atrioventricular block and reinfarction during their hospital stay, as compared to the placebo group. The authors concluded the DP appears to be safe in the prevention of potentially serious arrhythmias following myocardial infarctions.

In conclusion, DP seems to be an effective and well-tolerated antiarrhythmic agent in most patients with ventricular and atrial arrhythmias. Further evaluation is required to determine its ultimate benefit in long-term management of cardiac arrhythmias.

### References

<sup>1</sup>Vismara LA: Disopyramide phosphate: Clinical efficacy of a new oral antiarrhythmic drug. *Clin Pharm Thera* 16: 330-335 (June) 1974.

<sup>2</sup>Nichols AB: Efficacy of oral disopyramide phosphate for long-term treatment of ventricular arrhythmias. *Am J Cardiol* 37:159 (Jan) 1976.

<sup>3</sup>Jennings G *et al*: Oral disopyramide in prophylaxis of arrhythmias following myocardial infarction. *Lancet* 1: 51-54 (Jan 10) 1976.

### 2. Please provide information about the use of zinc sulfate in acne.

Articles have appeared over the last several years concerning the use of orally administered zinc sulfate for the treatment of leg ulcers, idiopathic loss of taste and smell, rheumatoid arthritis, gastric ulcer, and others. A preliminary study now has appeared which was conducted to determine the effects of zinc in acne vulgaris.

Michaelsson, *et al.*<sup>1</sup> conducted a double-blind study on 64 patients with acne. The patients were divided into four groups as follows: Group I received 0.2 zinc sulfate orally three times a day (equivalent to 135 mg of elemental zinc per day), group II received a placebo, group III received vitamin A, and group IV received a combination of vitamin A and zinc sulfate. Results were evaluated statistically at four weeks and twelve weeks of treatment, in terms of changes in comedones, papules, pustules, infiltrates, and cystic lesions in the face and submandibular region. The results indicated that zinc sulfate significantly decreased the number of papules, pustules, and infiltrates. No significant effect in different parameters was obtained with vitamin A, except for a decrease in the number of comedones. The authors indicate that although the mechanism of action of this agent is not clear in acne, zinc is known to be involved in the utilization of vitamin A as well as for the activation of at least 20 enzymes, some of which are present in the sebaceous gland.

In a letter to the editor, Fitzherbert<sup>2</sup> indicated that zinc deficiency may be an important etiological factor in the pathogenesis of acne, and that zinc/magnesium replacement did help young people suffering from acne vulgaris. On the other hand, Briggs<sup>3</sup> found no plasma zinc deficiency in patients with acne vulgaris, though the possibility of a localized epidermal depletion of zinc was not ruled out.

In conclusion, further studies are required to determine the place of zinc in the treatment of acne.

### References

<sup>1</sup>Michaelsson G *et al*: Effects of oral zinc and vitamin A in acne. *Arch Dermatol* 113:31-36 (Jan) 1977.

<sup>2</sup>Fitzherbert JC: Acne vulgaris-zinc deficiency. *Med J Aust* 1:848 (May) 1976.

<sup>3</sup>Briggs M: Acne vulgaris-zinc deficiency. *Med J Aust* 1: 1019 (June) 1976.

This month's column was prepared by J. M. Rosenberg, M.S., Pharm. D., T. M. John, B.S., M. K. Raina, M. Pharm., Ph.D., P. Sangkachand, B.S., Brooklyn College of Pharmacy, LIU.



### 3. What is the rationale for a once-daily dose of phenytoin in epileptic patients?

The need to take a drug less often has been shown to improve patient compliance, particularly if the medication is to be taken over extended periods of time. Pharmacokinetic principles warrant that the frequency of administration of a drug should approximate its half-life. Since the half-life of phenytoin (Dilantin®) is 18 to 24 hours, it is possible to administer the total requirement in a single dose rather than in 3 or 4 divided doses. This is recognized in the official literature for Dilantin®, in that a once-daily dosage of 300 mg is listed as an alternative therapy for those adults in whom seizure control has been established with 100 mg three times a day. The package insert does not list this alternate dosage schedule for children or those adults stabilized on some other dosage regimen.<sup>1</sup>

Haerer and Buchanan<sup>2</sup> studied the blood levels of phenytoin in 13 patients who were stabilized on the drug for control of epileptic seizures. The mean phenytoin concentration on admission to the study was 10.6 mcg/ml. (The accepted therapeutic range is 10-20 mcg/ml.)<sup>1</sup> Twenty-four hours later, all 13 patients were given the entire daily dose (average dose 4.9 mg/kg) in the morning, and this schedule was maintained throughout the study. Two days later, blood levels were monitored before the drug administration, and at 2, 4, 6, and 24 hours following the dosage. The procedure was again repeated one week later. Blood levels at different intervals following the single daily dose administration of phenytoin showed remarkable uniformity. The level at 24 hours after the single dose remained close to the four-hour peak concentration. There was no evidence of excessive or subtherapeutic blood levels. Neurologic evaluation obtained at each sampling failed to demonstrate any indication of toxicity.

A three-part study was conducted on institutionalized children who were stabilized on approximately 5 mg/kg of phenytoin per day, given in divided doses. Following four weeks of baseline observations (Part 1), they were changed to a single dose regimen of phenytoin (Part 2), and then returned to the divided dose regimen (Part 3). Serum phenytoin determinations were similar during the two different dosage regimens. No evidence of excessive drug accumulation occurred at the time of peak absorption following the single daily dose regimen, or was there a tendency for subtherapeutic levels just prior to the next daily dose.<sup>1</sup>

In conclusion, once-a-day dosage of phenytoin offers convenience to patients and nursing personnel; however, patients must be counseled not to miss inadvertently this dose, which would be more serious than missing one of the divided doses.

#### References

<sup>1</sup>Physician's Desk Reference, 31st Edition, Oradell, New Jersey, Medical Economics Company, 1977, pp 1175-1176.

<sup>2</sup>Haerer AF, Buchanan RA: Effectiveness of single daily dose of diphenylhydantoin. *Neurology* 22:1021-1025 (Oct) 1972.

<sup>3</sup>Buchanan RA, et al: Single daily dose of diphenylhydantoin in children. *J Pediatr* 83:479-483 (Sept) 1973.

## PHYSICIANS SEEKING LOCATION IN NEW JERSEY

*The following physicians have written to the Executive Office of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.*

**ANESTHESIOLOGY**—Ragaie Z. Kolta, M.D., 12700 Fairhill Road, Cleveland, Ohio 44120. Ein-Shams (Cairo, Egypt) 1960. Board eligible. Group, partnership. Available.

Takao Uchida, M.D., 1545 NW 8th Avenue, Apt. #108, Miami, Florida 33136. Gifu (Japan) 1973. Board eligible. Solo, single specialty group, partnership. Available.

Margarita Bravo, M.D., 51-15 Van Kleeck Street, Apt. 2-G, Elmhurst, New York 11373. Univ. of Philippines 1969. Board eligible. Group or partnership. Available.

**FAMILY PRACTICE**—Bruce E. Yeamans, M.D., 5025 A Street, Omaha, Nebraska 68106. Creighton 1974. Board eligible. Small group or partnership. Available.

Jin Baik Chung, M.D., 823 Harned Street, Apt. 2-A, Perth Amboy 08861. Catholic Medical College (Korea) 1968. Solo, partnership, group, emergency room. Available July 1978.

**GENERAL PRACTICE**—George A. Murr, III, M.D., 1611 South Broad Street, Philadelphia, Pennsylvania 19148. Hahnemann 1976. Subspecialty, emergency medicine. Group or emergency room. Available.

Terence T. Hart, M.D., 1474 Seymour Street, Apt. 5, Halifax, Nova Scotia, Canada. Subspecialty, emergency medicine. Partnership, group, or emergency room. Available.

Abdul Waheed, M.D., 5914 Shoshone Avenue, Encino, California 91316. Khyber Medical College (Pakistan) Partnership or group. Available.

Dan J. Hanco, M.D., 10 Muirhead Road, Apt. 1701, Willowdale M2J 4P9, Ontario, Canada. University of Toronto 1976. Partnership, school health, emergency room. Available.

**INTERNAL MEDICINE**—Philip Chathampathil, M.D., 1925 Eastchester Road, Apt. 16-D, Bronx, New York 10461. Trivandrum (India) 1968. Subspecialty, hematology/oncology. Board eligible. Hospital-based solo, group, teaching. Available.

Robin O. Motz, M.D., 1297 Dickerson Road, Teaneck 07666. Columbia University 1975. Single or multi-specialty group, research. Available July 1978.

Jeffrey M. Shapiro, M.D., 2991 School House Lane, Apt. #534E, Philadelphia, Pennsylvania 19144. Uni-



versity of Buenos Aires 1963. Subspecialty, gastroenterology. Board certified (IM). Solo, partnership, group. Available July 1978.

Myron A. Shoham, M.D., M.O.Q. 3011, Camp Lejeune, North Carolina 28542. Boston 1971. Subspecialty, gastroenterology. Board certified (IM). Group or partnership. Available July 1978.

Ira Spiler, M.D., 27 Sutherland Road, Brighton, Massachusetts 02146. Einstein 1971. Subspecialty, endocrinology. Board certified (IM). Group, partnership, or geographic (full time). Available July 1978.

John J. Halpin, M.D., 1089 Elmore Avenue, Columbus, Ohio 43224. Georgetown 1971. Subspecialty, hematology/oncology. Board certified (IM). Group or partnership. Available July 1978.

Bruce E. Sherling, M.D., 28-B Warren Drive, Edison 08817. NYU 1973. Subspecialty, pulmonary diseases. Board certified (IM). Group or hospital-based. Available July 1978.

Yune-Gill Jeong, M.D., 6-B Booker Creek Apt., Chapel Hill, North Carolina 27514. Chun Nam (Korea) 1970. Subspecialty, pulmonary medicine. Board certified (IM). Hospital-based or geographic full-time pulmonary subspecialist. Available July 1978.

**NEUROLOGY**—Hasit R. Thakore, M.D., 100 East 92nd Street, Apt. 5-A, Brooklyn, New York 11212. Municipal Medical School (India) 1968. Board eligible. Group, hospital-based, partnership. Available.

Sadasivam Modali, M.D., 51-55 Van Kleeck Street, Apt. 3-J, Elmhurst, New York 11373. Kurnool Medical College (India) 1964. Board eligible. Group, partnership, or hospital practice. Available.

Lester Hershman, M.D., 500 East 85th Street, Apt. 3-F, New York, New York 10028. Mt. Sinai (NYC) 1974. Board eligible. Group, partnership, solo. Available July 1978.

**OBSTETRICS/GYNECOLOGY**—R. George Cherian, M.D., 3450-21N Wayne Avenue, Bronx, New York 10467. Kasturba (India) 1970. Board eligible. Solo or partnership. Available.

Louis J. Freedman, M.D., 210 Locust Street, Apt. 12-A, Philadelphia, Pennsylvania 19106. University of Pennsylvania. Group (specialty) or partnership. Available July 1978.

Akbar Omar, M.D., 85 Riverdale Avenue, Apt. A-642, Yonkers, New York 10701. Dow, Karachi (Pakistan). Solo, partnership, or group. Available July 1978.

Leonard Pass, M.D., 6 Douglas Mowbray Road, Peekskill, New York 10566. Board certified. Solo, partnership, or group. Available September 1977.

Parimal S. Bhayani, M.D., 1275 Rock Avenue, Apt. KK-7, North Plainfield 07060. Univ. of Bombay 1968. Board eligible. Group or partnership. Available.

**OPHTHALMOLOGY**—Frederick C. Blades, M.D., 499 River Road, Fair Haven 07701. George Washington University 1969. Board eligible. Part-time, close to Red Bank. Available.

Davinder Singh Rehsia, M.D., 504-671 William Avenue, Winnipeg R3E 0Z2, Manitoba, Canada. Amritsar, Punjab (India) 1969. Board eligible. Group, partnership, or emergency room. Available. December 1977.

Howard Jay Gross, M.D., 3115 Breton Avenue, Davis, California 95616. George Washington University 1971. Board eligible. Solo, partnership, group. Available April 1978.

**ORTHOPEDIC SURGERY**—Michael Hahn, M.D., 85 Schuyler Drive, Edison 08817. NYU (Downstate) 1969. Board Eligible. Group or partnership. Available.

Jeffery H. Phillips, M.D., 3450-23 Wayne Avenue, Bronx, New York 10467. Einstein 1974. Group or partnership. Available July 1978.

**PATHOLOGY**—Vasundhara G. Bindinganavile, M.D., 42 Walnut Street, Montclair 07042. Bangalore Medical College (India) 1969. Group or institutionally-based. Available July 1978.

Surabhan Ratanasen, M.D., 156 Corliss Avenue, Apt. 706, Johnson City, New York 13790. Chulalongkorn, Bangkok (Thailand) 1971. Board eligible. Solo, partnership, or group. Available October 1977.

Moo Keun Lee, M.D., 120 Randolph Road, Apt. #48, Plainfield 07060. Yonsei (Korea) 1968. Group or partnership. Available July 1978.

**PEDIATRICS**—Richard E. Manners, M.D., 11801 Monroe Street, N.E., Blaine, Minnesota 55434. Einstein 1975. Board eligible. University affiliated or group practice. Available July 1978.

Edward P. Spiegel, M.D., 1008 Vienna Woods Drive, Cincinnati, Ohio 45211. University of Pennsylvania 1972. Board eligible. Partnership or group. Available August 1978.

Fazal Ahmad, M.D., 100 College Avenue, Apt. 6-S, North Tarrytown, New York 10591. Karachi (Pakistan) 1969. Board eligible. Any type of practice. Available.

Allen S. Retirado, M.D., 639 Albany Avenue, Apt. 4-J, Brooklyn, New York 11203. U.E. College of Medicine (Philippines) 1971. Board eligible. Group, partnership, hospital or institutionally based. Available.

Johannes B. Lukito, M.D., 2101 Canarsie Road, Brooklyn, New York 11236. University of Indonesia 1969. Board eligible. Subspecialty, hematology. Solo, partnership, or group. Available January 1978.

**RADIOLOGY**—Sun Hyung Park, M.D., 230 Elruth Court, Apt. 86, Girard, Ohio 44420. Yonsei University (Korea) 1972. Board eligible. Solo, partnership, group, institutional. Available November 1977.

**SURGERY**—Por-Ming Luo, M.D., 10428 South Mason Avenue, Apt. 2-S, Oak Lawn, Illinois 60453. Taipei (Taiwan) 1967. Board eligible. Solo, group, partnership. Available.

George E. Wilkinson, Jr., M.D., 98 Marchmont Crescent, Edinburgh EH9 1HD, Scotland. CMDNJ 1972. Board eligible. Group. Available.

Jorge Antonio Melendez, M.D., 1 Hillside Drive, Batavia, New York 14020. San Agostin University (Peru) 1967. Board certified. Partnership, group, institutionally based. Available August 1978.

Sham Yung, M.D., 1035 Beach Road, Apt. B-10, Cheektowaga, New York 14225. Chung Shan Medical College (Taiwan) 1972. Board eligible. Solo, partnership, group, emergency room. Available December 1977.

Irvathur Narasimha Nayak, M.D., 115 Old Short Hills Road, Apt. 526, West Orange 07052. Stanley Medical College, Madras (India) 1963. Board eligible. Solo, partnership, group. Available January 1978.

James Fredrick Davison, 3699 Kendall Avenue, Cincinnati, Ohio 45208. St. Louis University 1972. Special interest, urological surgery. Partnership or group. Available July 1978.

Richard J. Winkle, M.D., 114 Country Club Road, Willingboro 08046. Cornell 1960. Board certified. Sub-specialty, thoracic and vascular surgery. Available.

**UROLOGY**—Sharat C. Kalvakota, M.D., 50 Yonkers Terrace, Yonkers, New York 10704. Gandhi Medical College (India) 1968. Group, solo, or full-time hospital-based. Available July 1978.

P. Satpathy, M.D., 6517 Landover Road, Apt. 102, Cheverly, Maryland 20785. Utkal (India) 1965. Board eligible. Any type of practice. Available.

Bruce Devon, M.D., 675 Delaware Avenue, Buffalo, New York 14202. Tufts 1973. Board eligible. Solo, partnership, or group. Available July 1978.

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 Jesse Schulman, M.D., *Consultant* ..... Lakewood  
 B. F. Slobodien, M.D., *Consultant* ..... Perth Amboy

**Medical Education**

Arthur Bernstein, M.D., *Chairman* (1980) ..... Maplewood  
 Frank C. Snope, M.D., *Vice-Chairman* .....  
 (1979) ..... Piscataway  
 Alfred A. Alessi, M.D. (1980) ..... Hackensack  
 Maurice J. Elovitz, M.D. (1979) ..... Atlantic City  
 Edward H. Weiser, M.D. (1978) ..... Sussex  
 Sidney Woltz, M.D. (1978) ..... Union City  
 Paul J. Hirsch, M.D., *Consultant* ..... Bridgewater  
 Edwin W. Messey, M.D., *Consultant* ..... Willingboro  
 William F. Minogue, M.D., *Consultant* ..... Summit  
 Robert S. Rigolosi, M.D., *Consultant* ..... Paramus  
 James A. Rogers, M.D., *Consultant* ..... Paterson  
 William S. Vaun, M.D., *Consultant* ..... Long Branch

**Medical Student Loan Fund**

William Greifinger, M.D., *Chairman* (1978) ..... Belleville  
 Charles Cunningham, M.D., *Vice-Chairman* .....  
 (1979) ..... Vineland  
 Antonio P. Battaglia, M.D. (1979) ..... Gibbstown  
 William R. Muir, M.D. (1977) ..... Mount Holly  
 James P. Thompson, M.D. (1980) ..... Upper Montclair

**Publication**

Daniel B. Roth, M.D., *Chairman* (1979) ..... Teaneck  
 John F. Marshall, M.D., *Vice-Chairman* .....  
 (1978) ..... Trenton  
 Julio delCastillo, M.D. (1980) ..... Trenton  
 Charles S. Krueger, M.D., *President-Elect*, .....  
 Ex-Officio ..... Teaneck  
 Arthur Bernstein, M.D., *Secretary*, .....  
 Ex-Officio ..... Maplewood  
 Arthur Krosnick, M.D., *Editor*, Ex-Officio ..... Trenton

**Revision of Constitution and Bylaws**

Hillel M. Ben-Asher, M.D., *Chairman* .....  
 (1978) ..... Morristown  
 Daniel J. O'Regan, M.D., *Vice-Chairman* .....  
 (1979) ..... Jersey City  
 A. Guy Campo, M.D. (1979) ..... Westville  
 Lawrence B. Owen, M.D. (1980) ..... Woodstown  
 Carl A. Restivo, M.D. (1978) ..... Jersey City  
 Arthur G. Sullivan, Jr., M.D. (1980) ..... Bound Brook  
 Arthur Bernstein, M.D., *Secretary*, .....  
 Ex-Officio ..... Maplewood  
 John S. Madara, M.D., *Consultant* ..... Salem  
 Charles I. Nadel, M.D., *Consultant* ..... Irvington



## ADMINISTRATIVE COUNCILS

### Council on Legislation

Daniel J. O'Regan, M.D., <i>Chairman</i> (1980)	Jersey City
John D. Franzoni, M.D., <i>Vice-Chairman</i> (1979)	Trenton
Meyer L. Abrams, M.D. (1980)	Cherry Hill
Donald P. Burt, M.D. (1978)	Morristown
John J. Crosby, Jr., M.D. (1979)	Jersey City
William J. D'Elia, M.D. (1980)	Spring Lake
Leon A. Fraser, M.D. (1979)	Trenton
Winton H. Johnson, M.D. (1978)	Hackensack
Henry J. Mineur, M.D. (1978)	Cranford
Samuel B. Pole, III, M.D. (1978)	Bridgeton
Ernest S. Redfield, M.D. (1979)	Woodbury
John R. Tobey, M.D. (1980)	Newark
James S. Todd, M.D., <i>Chairman, Board of Trustees, Ex-Officio</i>	Ridgewood

### Council on Medical Services

Victor H. Boogdanian, M.D., <i>Chairman</i> (1980)	New Brunswick
John S. Madara, M.D., <i>Vice-Chairman</i> (1978)	Salem
Robert H. Areson, M.D. (1978)	Montclair
James Q. Atkinson, M.D. (1979)	Medford Lakes
Frank Campo, M.D. (1979)	Trenton
Arthur C. Dietrick, M.D. (1978)	Mount Holly
Armando F. Goracci, M.D. (1978)	Woodbury
Edward P. Healey, M.D. (1978)	Clifton
John R. O'Brien, M.D. (1979)	Jersey City
Richard H. Sharrett, M.D. (1980)	Plainfield
Charles O. Tyler, M.D. (1980)	Cherry Hill
Sidney Woltz, M.D. (1979)	Union City
Charles S. Krueger, M.D., <i>President-Elect Ex-Officio</i>	Mount Holly
Matthew E. Boylan, M.D., <i>Consultant</i>	Avon-By-The-Sea
A. Guy Campo, M.D., <i>Consultant</i>	Westville
Karl T. Franzoni, M.D., <i>Consultant</i>	Trenton
Frank M. Galioto, M.D., <i>Consultant</i>	Bloomfield
Joseph A. Lepree, M.D., <i>Consultant</i>	Elizabeth
N. E. Marchione, M.D., <i>Consultant</i>	Vineland
James A. Rogers, M.D., <i>Consultant</i>	Paterson

### Special Committee to Council on Medical Services

#### Occupational Health, Workmen's Compensation, and Rehabilitation

Elmer J. Elias, M.D., <i>Chairman</i>	Trenton
Mathilda R. Vaschak, M.D., <i>Vice-Chairman</i>	North Plainfield
John W. Holdcraft, M.D.	Woodbury
Andrew G. Hudacek, M.D.	Morristown
M. Noel Jennings, M.D.	Holmdel
Matthew M. Mishinski, M.D.	Camden
Daniel J. O'Regan, M.D.	Jersey City
William D. Van Riper, M.D.	Green Pond
Ralph A. Young, M.D.	Maplewood
Joshua N. Zimskind, M.D.	Trenton
William E. Neeld, M.D., <i>Consultant</i>	Deepwater

### Council on Mental Health

Robert S. Garber, M.D., <i>Chairman</i> (1978)	Belle Mead
Harry H. Brunt, Jr., M.D. (1980)	Neptune
<i>Vice-Chairman</i>	Hammononton
Farrell R. Crouse, M.D. (1979)	Rochelle Park
Ralph J. Fioretti, M.D., (1980)	Farmingdale
Evelyn P. Ivey, M.D. (1978)	Livingston
Alvin Friedland, M.D. (1980)	Vineland
Alan Kulick, M.D. (1979)	Livingston
Seymour F. Kuvin, M.D. (1979)	Wayne
Gerald H. Rozan, M.D. (1980)	Beach Haven
G. L. Triebenbacher, M.D. (1979)	Trenton
Martin H. Weinberg, M.D. (1978)	
John S. Madara, M.D., <i>Immediate Past-President, Ex-Officio</i>	Salem
Robert S. Albahary, M.D., <i>Consultant</i>	New Brunswick
Joseph J. Kline, M.D., <i>Consultant</i>	Trenton
J. Lloyd Morrow, M.D., <i>Consultant</i>	Passaic
Laura E. Morrow, M.D., <i>Consultant</i>	Passaic

### Council on Public Health

John J. Pastore, M.D., <i>Chairman</i> (1978)	Vineland
Edward M. Coe, M.D. (1980)	Cranford
<i>Vice-Chairman</i>	East Orange
William M. Chase, M.D. (1979)	Neptune City
Anthony P. DeSpirito, M.D. (1978)	Hackensack
Peter A. Gross, M.D. (1979)	Metuchen
Thomas F. McLaughlin, M.D. (1979)	Riverton
Watson E. Neiman, M.D. (1980)	Highlands
Francis E. Rieman, M.D. (1978)	New Brunswick
Bernard A. Rineberg (1980)	North Wildwood
Robert G. Salasin (1978)	Cliffside Park
Robert E. Verdon (1980)	Glen Rock
Edward A. Wolfson, M.D. (1979)	
Alfred A. Alessi, M.D., <i>First Vice-President Ex-Officio</i>	Hackensack
William J. Dougherty, M.D., <i>Consultant</i>	Trenton
Martin Goldfield, M.D., <i>Consultant for Communicable and Infectious Diseases</i>	Trenton

### Special Committees to Council on Public Health

#### Cancer Control

Roy T. Forsberg, M.D., <i>Chairman</i>	Westfield
Sherman Garrison, M.D.	Bridgeton
Warren H. Knauer, M.D.	Hillside
George P. Koeck, M.D.	Hopatcong
Bernard J. Koven, M.D.	Englewood
Charles S. Krueger, M.D.	Mount Holly
John H. Landon, M.D.	Greenbrook
Albert A. Pineda, M.D.	Clifton
Benjamin F. Rush, Jr., M.D.	Newark
Elissa J. Santore, M.D.	Irvington
Eva B. Stahl, M.D.	New Brunswick

#### Child Health

Glenn P. Lambert, M.D., <i>Chairman</i>	Flemington
Frank Colantuono, M.D.	Teaneck
William J. Farley, M.D.	Brielle
Douglas Ford, M.D.	East Orange
Robert E. Jennings, M.D.	South Orange
John J. LaMar, Jr., M.D.	Salem
Milton Prystowsky, M.D.	Nutley
Sidney Tucker, M.D.	Perth Amboy

### Conservation of Hearing and Speech

Aris M. Sophocles, M.D., <i>Chairman</i>	Trenton
Ralph L. Dicker, M.D.	Dover
Howard S. Farmer, M.D.	Princeton
Patrick Houston, M.D.	Cherry Hill
Donald J. Nalebuff, M.D.	Teaneck
Rowan C. Pearce, Jr., M.D.	Haddonfield
Isadore M. Schnee, M.D.	Paterson
Robert Stern, M.D.	Mount Holly

### Conservation of Vision

Samuel B. Pole, III, M.D., <i>Chairman</i>	Bridgeton
Jordan D. Burke, M.D.	Summit
Alfonse A. Cinotti, M.D.	Jersey City
Samuel Diskan, M.D.	Atlantic City
Oram R. Kline, M.D.	Camden
Ralph E. Siegel, M.D.	Perth Amboy
Ralph A. Skowron, M.D.	Cherry Hill
Anthony M. Sellitto, M.D., <i>Consultant</i>	South Orange

President and President-Elect, New Jersey Academy of Ophthalmology and Otolaryngology also are *Consultants*.

### Environmental Health

Richard H. Musgnug, M.D., <i>Chairman</i>	Medford Lakes
Seymour Charles, M.D.	Irvington
E. Spencer Paisley, M.D.	Haddon Heights
Philip J. G. Quigley, M.D.	Elizabeth
Frank L. Rosen, M.D.	Maplewood
William I. Weiss, M.D.	Livingston
Meyer T. Weissman, M.D.	Elizabeth
Owen A. Shteir, M.D.	Princeton
William I. Weiss, M.D.	Livingston
Meyer T. Weissman, M.D.	Elizabeth
Morris Joselow, Ph.D., <i>Consultant</i>	Westwood

### Council on Public Relations

James A. Rogers, M.D., <i>Chairman</i> (1978)	Paterson
Frank Y. Watson, M.D., <i>Vice-Chairman</i> (1980)	Montclair
Frank R. Begen, M.D. (1978)	Teaneck
Milton R. Bronstein, M.D. (1979)	Edison
Andrew G. Hudacek, M.D. (1978)	Morristown
Frank J. Malta, M.D. (1980)	Toms River
Robert E. McNamara, M.D. (1979)	Elizabeth
Edwin W. Messey, M.D. (1979)	Willingboro
Gastone A. Milano, M.D. (1978)	Atlantic City
Jesse Schulman, M.D. (1980)	Lakewood
Ford C. Spangler, M.D. (1979)	Salem
B. Ralph Wayman, Jr., M.D. (1980)	Morrisville, Pa.
George L. Benz, M.D., <i>2nd Vice-President</i> , Ex-Officio	Newark

## SPECIAL COMMITTEES

### Chronically Ill and Aging

Matthew E. Boylan, M.D., <i>Chairman</i>	Avon-By-The-Sea
Werner J. Hollendonner, M.D.	Trenton
Michael K. Kurilla, M.D.	Trenton
A. Gerard Peters, M.D.	Paterson

### Emergency Medical Care

Jack R. Karel, M.D., <i>Chairman</i>	Hillside
R. Winfield Betts, M.D., <i>Vice-Chairman</i>	Medford
Clifford B. Blasi, M.D.	Sea Girt
John A. Flood, Jr., M.D.	Trenton
David A. Gehring, M.D.	Woodbury
Christine E. Haycock, M.D.	Newark
Dorson S. Mills, M.D.	Elmer
Kenneth A. Morrisey, M.D.	Teaneck
Daniel J. O'Regan, M.D.	Jersey City
Stephen J. Rodgers, M.D.	Alloway
Rudolph E. Schwaeble, M.D.	Mendham
Michael D. Yablonski, M.D.	Hackensack
Watson E. Neiman, M.D., <i>Consultant</i>	Trenton

### Long Range Planning and Development

William J. D'Elia, M.D. (1978)	
<i>Chairman</i>	Spring Lake
Alfred A. Alessi, M.D. (1978)	Hackensack
H. Oliver Brown, M.D. (1978)	Westfield
Leon C. Edwards, M.D. (1978)	Bedminster
Edward P. Healey, M.D. (1978)	Clifton
Philip J. LoPresti, M.D. (1978)	Haddon Heights
Thomas E. Mattingly, Jr., M.D. (1978)	Mount Holly
Bernard Robins, M.D. (1978)	Springfield
Benjamin Wolfson, M.D. (1978)	Woodbury

### Medicine and Religion

Thomas H. McGlade, M.D., <i>Chairman</i>	Camden
Reynold E. Burch, M.D.	Newark
Charles H. Calvin, M.D.	Edison
Louis McAfoos, M.D.	Cherry Hill
Watson E. Neiman, M.D.	Cinnaminson
George A. Nitshe, M.D.	Monroeville
Edward W. Verner, M.D.	Newark

### Retirement Plan for Physicians

Nicholas E. Marchione, M.D., <i>Chairman</i>	Vineland
Paul J. Kreutz, M.D.	Elizabeth
Albert F. Moriconi, M.D.	Trenton
Emanuel M. Satulsky, M.D.	Elizabeth

# 212th Annual Meeting May 6-9 — Atlantic City

# 1977-1978

## Special Committees and Liaison Representatives

### Academy of Medicine of New Jersey

- (1) Board of Trustees/Liaison Committee  
(Liaison requested by Academy—6/19/66)  
Edward G. Bourns, M.D. . . . . Jamesburg  
James A. Rogers, M.D. . . . . Paterson  
Howard D. Slobodien, M.D. . . . . Perth Amboy
- (2) Post-Graduate Medical Education Study Committee  
(Representative requested by Academy—11/15/64)  
Arthur Bernstein, M.D., *Chairman*,  
*Committee on Medical Education* . . . . . Maplewood  
Frank C. Snope, M.D., *Vice Chairman*,  
*Committee on Medical Education* . . . . . Piscataway

### Aging, Children, and Youth, Auxiliary Committee.

(Liaison requested by MSNJ's Auxiliary—11/19/72)  
James A. Rogers, M.D. . . . . Paterson

### American Medical Association-Education Research Foundation

(Liaison requested by AMA-10/7/51)  
William Greifinger, M.D., *Chairman, Committee on Medical Student Loan Fund* . . . . . Belleville

### American Medical Student Association—CMDNJ

(Liaison established by the Board 4/25/76)  
Mr. David DeVere  
Mr. Leonard Bielory

### Audit Review Committee (1976-1977)

(Appointed annually by Board to review previous year's audit)

Louis F. Albright, M.D., *Chairman* . . . . . Spring Lake  
Edward G. Bourns, M.D. . . . . Jamesburg  
Matthew E. Boylan, M.D. . . . . Avon-by-the-Sea  
Charles L. Cuniff, M.D. . . . . Jersey City  
William J. D'Elia, M.D. . . . . Spring Lake

#### Consultants:

Rudolph C. Gering, M.D., *Treasurer* . . . . . Trenton  
Richard E. Lang, M.D., *Chairman, Committee on Finance and Budget* . . . . . Passaic  
Louis G. McAfoos, Jr., M.D., *Vice-Chairman, Committee on Finance and Budget* . . . . . Cherry Hill

### Blood Bank Association, New Jersey

(Liaison requested by New Jersey Blood Bank Association 4/25/69)  
Frank Campo, M.D. . . . . Trenton

### Blue Cross-Blue Shield Plans of New Jersey, Permanent Committee on

(Appointment of committee requested by MSP—4/16/60)  
James S. Todd, M.D., *Chairman*,  
*Board of Trustees* . . . . . Ridgewood  
Frank R. Begen, M.D., *President* . . . . . Teaneck  
Mr. Vincent A. Maressa, *Executive Director* . . . . . Trenton  
Equal Representation from:  
Medical-Surgical Plan of New Jersey  
Hospital Service Plan of New Jersey  
New Jersey Hospital Association

### Board of Institutional Trustees, Department of Institutions and Agencies

(Appointed by Governor for 8-year term)  
Frank J. Hughes, M.D. (1979) . . . . . Gloucester

### Board of Nursing, New Jersey State

(Liaison requested by Board of Nursing—11/21/65)  
Henry J. Mineur, M.D. . . . . Cranford

### Bureau of Investigation, Department of Law and Public Safety

(Cooperating committee requested by Department of Law and Public Safety—9/61)  
Board of Trustees (Reaffirmed by Board of Trustees 5/17/77)

### Cardiac Advisory Panel to Director of Motor Vehicles

(Panel requested by Special Commission on Traffic Safety—9/17/61—appointed by Director of Motor Vehicles)  
James G. Kehler, M.D. . . . . Woodbury

### Community Medicine Advisory Council

(MSNJ representation requested by Richard J. Cross, M.D., CMDNJ at Rutgers—12/20/70)  
Arthur Bernstein, M.D. . . . . Maplewood  
Victor H. Boogdian, M.D. . . . . New Brunswick

### Comprehensive Health Planning Agency

(Liaison requested by the Comprehensive Health Planning Agency—12/16/69)  
Nicholas E. Marchione, M.D., *State Health Planning Council* . . . . . Vineland  
Irving P. Borsher, M.D., *Health Care Costs Committee* . . . . . Newark  
Arthur Bernstein, M.D., *Medicaid Committee* . . . . . Maplewood  
James A. Rogers, M.D., *Medical Education Facilities Committee* . . . . . Paterson

### Consumer Health Education, Advisory Committee of the Office of

(College of Medicine and Dentistry of New Jersey)  
Howard D. Slobodien, M.D. . . . . Perth Amboy

### Crippled Children Commission, State

(Appointed by Governor for 5-year term)  
Harry W. Fullerton, Jr., M.D. . . . . Carney's Point

### Disputed Claims, Advisory Committee to Review MSP and HSP

(Established at request of MSP—8/21/60—Quorum:4 members)

1st District—  
Ralph M. L. Buchanan, M.D.,  
*Chairman* . . . . . Phillipsburg  
Gustav L. Ibranyi, M.D. . . . . Newark  
2nd District—  
John J. Crosby, Jr., M.D. . . . . Jersey City  
Carl A. Restivo, M.D. . . . . Jersey City  
3rd District—  
John S. VanMater, M.D. . . . . New Brunswick  
John A. Kinzel, M.D. . . . . Trenton  
4th District—  
Frank J. Hughes, M.D. . . . . Gloucester  
5th District—  
Don B. Weems, Jr., M.D. . . . . Wenonah  
Nicholas E. Marchione, M.D. . . . . Vineland



#### Education, State Department of

(Liaison requested by the Assistant Commissioner of  
Education—9/21/58)  
Glenn P. Lambert, M.D., *Chairman, Special  
Committee on Child Health* ..... Flemington

#### Emotionally Disturbed Child, Advisory Council to Department of Education

(Liaison requested by Department of Education—  
10/28/68)  
William J. Farley, M.D. .... Brielle

#### Epilepsy, Advisory Panel to State Director of Motor Vehicles

(Established at request of Director of Motor Vehicles  
—7/29/66)  
J. Berkeley Gordon, M.D. .... Rumson

#### Executive Committee

(Provided in the Bylaws, Chapter III (c))  
Frank R. Begen, M.D., *President* ..... Teaneck  
(*Chairman*)  
Charles S. Krueger, M.D., ..... Mt. Holly  
*President-Elect*  
Alfred A. Alessi, M.D., ..... Hackensack  
*First Vice-President*  
George L. Benz, M.D., ..... Newark  
*Second Vice-President*  
James S. Todd, M.D., *Chairman of the* ..... Ridgewood  
*Board of Trustees*  
John S. Madara, M.D., ..... Salem  
*Immediate Past-President*

#### Graduate Education, Task Force on

(Representation requested by CMDNJ)  
James A. Rogers, M.D. .... Paterson

#### Health Care Administration Board

MSNJ Executive Committee members and Trustees  
(on an alphabetical, rotating basis) notified of meeting  
dates. (Per Board action 2/15/76)

#### Health Insurance Association of America

(Committee established at request of Health Insurance  
Council—3/24/57)  
Arthur Bernstein, M.D., *Secretary* ..... Maplewood  
(*Chairman*)  
Frank R. Begen, M.D., *President* ..... Teaneck  
Charles S. Krueger, M.D., ..... Mount Holly  
*President-Elect*  
Alfred A. Alessi, M.D., *First* ..... Hackensack  
*Vice-President*  
George L. Benz, M.D., *Second* ..... Newark  
*Vice-President*  
Mr. Vincent A. Maressa, *Executive Director* ..... Trenton

#### Health Professions Education Advisory Council

(Department of Higher Education)  
William J. D'Elia, M.D. .... Spring Lake  
John J. Crosby, Jr., M.D. .... Jersey City

#### Historian-Archivist

(Created at the suggestion of the Executive Director—  
1/13/57)  
Morris H. Saffron, M.D. (Appointed 5/67) ..... Passaic

#### Home Health Agencies, State Committee to Develop Standards for Licensure of

(MSNJ representation requested by the Secretary of the  
Licensure Committee of the New Jersey Department of  
Health—10/15/72)  
David Eckstein, M.D. .... Trenton

#### Hospital Association, New Jersey

(Liaison established at request of New Jersey Hospital  
Association—12/17/67)  
Rudolph C. Gering, M.D. .... Trenton

#### Hospital Advisory Council, State Department of Health

(Appointed by the Commissioner of Health for an  
indefinite term)  
Nicholas E. Marchione, M.D. .... Vineland

#### House Maintenance, Staff Policies and Personnel Relations

(Special Committee created by Board of Trustees—  
9/21/58)  
Frank R. Begen, M.D., *President* ..... Teaneck  
(*Chairman*)  
Charles S. Krueger, M.D., *President-Elect* ..... Mt. Holly  
Arthur Bernstein, M.D., *Secretary* ..... Maplewood  
Rudolph C. Gering, M.D., *Treasurer* ..... Trenton  
James S. Todd, M.D., *Chairman,* ..... Ridgewood  
*Board of Trustees*  
Richard E. Lang, M.D., *Chairman,* ..... Cherry Hill  
*Committee on Finance and Budget*  
Mr. Vincent A. Maressa, *Executive Director* ..... Trenton

#### JEMPAC, Conference Committee with

(Established at request of JEMPAC—6/25/67)  
Daniel J. O'Regan, M.D., *Chairman* ..... Jersey City  
*Council on Legislation*  
Victor H. Boogdanian, M.D., *Chairman* ..... New Brunswick  
*Council on Medical Services*  
George L. Benz, M.D., *Second* ..... Newark  
*Vice-President*

#### Judiciary and Bar, Conference Committee on Inter-Relations with the

(Established at invitation of Supreme Court—11/17/63)  
Frank R. Begen, M.D., *President* ..... Teaneck  
Charles S. Krueger, M.D., *President-Elect* ..... Mount Holly  
Alfred A. Alessi, M.D., ..... Hackensack  
*First Vice-President*  
George L. Benz, M.D., ..... Newark  
*Second Vice-President*  
James S. Todd, M.D., *Chairman* ..... Ridgewood  
*Board of Trustees*  
Arthur Bernstein, M.D., *Secretary* ..... Maplewood  
Rudolph C. Gering, M.D., *Treasurer* ..... Trenton  
Daniel J. O'Regan, M.D., *Chairman* ..... Jersey City  
*Council on Legislation*  
Paul J. Kreutz, M.D., *Chairman, Committee on* ..... Elizabeth  
*Medical Defense and Insurance*  
William J. D'Elia, M.D. .... Spring Lake  
James E. George, M.D. .... Woodbury  
Elmer L. Grimes, M.D. .... Haddonfield  
Nicholas E. Marchione, M.D. .... Vineland  
James A. Rogers, M.D. .... Paterson  
Emanuel M. Satulsky, M.D. .... Elizabeth  
Mr. Vincent A. Maressa, *Executive Director* ..... Trenton

Mr. Joseph C. Lucci, *Executive Assistant* ..... Trenton  
 Equal representation from:  
 Supreme Court Committee on Relations with the  
 Medical Profession

#### Legislation

- (1) Federal Keymen  
 (Mechanism established by MSNJ—4/4/54—to serve  
 as official intermediaries between MSNJ and the  
 Federal legislators)  
 15 Congressional District Keymen  
 1 Senatorial Keyman
  - (2) State Keymen  
 (Mechanism established by MSNJ—7/13/52)  
 Keymen in 15 Legislative Districts/21 Component  
 Societies
- List maintained by Council on Legislation and Jempac

#### Medicaid, Committee on

(Established by the Board on 9/21/75, at the request of  
 the Essex County Medicaid Committee)  
 Daniel J. O'Regan, M.D., *Chairman*  
*Council on Legislation* ..... Jersey City  
 Victor H. Boogdanian, M.D., *Chairman*  
*Council on Medical Services* ..... New Brunswick  
 John W. Alexander, M.D. .... Newark  
 Seymour Charles, M.D. .... Irvington  
 Harvey J. Shwed, M.D. .... Newark  
 Representatives from county and specialty societies

#### Medicaid Peer Review Committee

(Established by Board of Trustees 4/19/70 at the request  
 of the Department of Institutions and Agencies. The func-  
 tion of the Committee will be to act upon inquiries and/or  
 complaints originating either with the administrators of the  
 Medicaid Program or with physicians serving under the  
 program.)

1st District—  
 Nicholas A. Bertha, M.D. .... Wharton

2nd District—  
 Ambrose P. Boyle, Jr., M.D. .... Teaneck

3rd District—  
 Rudolph C. Gering, M.D. .... Trenton

4th District—  
 Emanuel Abraham, M.D. .... Neptune

5th District—  
 Jesse Carll, IV, M.D. .... Bridgeton

#### Medical Assistance Advisory Council

(Established at invitation of State Medicaid Commission  
 — Board action 4/20/69)  
 A. Guy Campo, M.D. .... Westville  
 Anthony P. DeSpirito, M.D. .... Asbury Park

#### Medical Assistants, (State of New Jersey) American Association of

(Liaison requested by Association—9/15/63)  
 William J. D'Elia, M.D. .... Spring Lake

#### Medical Liaison Committees

(High-level conference groups for discussion and  
 consideration of items of mutual interest)  
 Frank R. Begen, M.D., *President* ..... Teaneck  
 Charles S. Krueger, M.D., *President-Elect* ..... Mt. Holly

John S. Madara, M.D., *Immediate*  
*Past-President* ..... Salem

James S. Todd, M.D., *Chairman, Board*  
*of Trustees* ..... Ridgewood

Mr. Vincent A. Maressa, *Executive Director* ..... Trenton

(Where number of representatives from other organi-  
 zation is larger than number of MSNJ representatives, the  
 latter will be increased from the Presidential Officers to  
 equal the former.)

- (1) Medical-Dental  
 (Liaison requested by the Dental Society—6/10/51)
- (2) Medical-Hospital  
 (Liaison established by MSNJ—10/25/53)
- (3) Medical-Legal  
 (Liaison established by MSNJ—10/25/53)
- (4) Medical-Nursing  
 (Liaison established by MSNJ—4/4/54)
- (5) Medical-Osteopathic  
 (Liaison requested by Osteopathic Association—  
 9/17/61)
- (6) Medical-Pharmaceutical  
 (Liaison established by MSNJ—7/26/53)

#### Medical-Surgical Plan Board of Trustees

(Provided in MSP Bylaws)  
 Frank R. Begen, M.D., *President* ..... Teaneck

#### Medicare Peer Review Committee

(Established by Board of Trustees 12/20/70 at request of  
 fiscal intermediary. Committee will review and evaluate  
 claims involving questions of over-utilization under Medi-  
 care. Composition of committee includes six groups of three  
 members each in the fields of general practice, general  
 surgery, orthopedic surgery, internal medicine, ophthal-  
 mology, and urology.)

#### Membership Directory

(Special committee established by Board—11/19/61)  
 Arthur Bernstein, M.D., *Chairman* ..... Maplewood  
 Matthew E. Boylan, M.D. .... Avon-by-the-Sea  
 William Greifinger, M.D. .... Belleville  
 Daniel B. Roth, M.D. .... Teaneck  
 Mr. Vincent A. Maressa, *Executive Director* ..... Trenton  
 Mr. Robert H. Lambert, *Director,*  
*Fin. and Admin. Services* ..... Trenton

#### Membership Inquiry and Complaint Mechanism

(Established at the 12/10/72 Special Session of the  
 House of Delegates to deal more effectively with third party  
 insurance carriers and government medical programs as  
 they affect the practices of the membership.)

#### Membership Inquiry and Complaint Committee with Medical-Surgical Plan of New Jersey

Samuel Baum, M.D. .... Passaic  
 Donald P. Burt, M.D. .... Morristown  
 Arthur C. Dietrick, M.D. .... Mount Holly  
 Karl T. Franzoni, M.D. .... Trenton  
 James E. George, M.D. .... Woodbury

#### Membership Inquiry and Complaint Committee with Medicare

Alfred A. Alessi, M.D. .... Hackensack  
 William H. Coleman, M.D. .... Trenton  
 Richard H. DuPree, M.D. .... Woodbury

Andrew G. Hudacek, M.D. . . . . . Morristown  
Joseph W. Schauer, Jr., M.D. . . . . . Farmingdale

**Membership Inquiry and Complaint Committee with Medicaid**

John J. Crosby, Jr., M.D. . . . . . Jersey City  
Michael J. Doyle, M.D. . . . . . Neptune  
Armando F. Goracci, M.D. . . . . . Woodbury  
Frederick J. Knocke, M.D. . . . . . Flemington  
Robert E. McNamara, M.D. . . . . . Elizabeth

**Membership Inquiry and Complaint Committee with Other Carriers**

Melvin J. Andrews, M.D. . . . . . Cherry Hill  
Emanuel M. Satulsky, M.D. . . . . . Elizabeth  
Howard D. Slobodien, M.D. . . . . . Perth Amboy  
Robert A. Weinstein, M.D. . . . . . Newton  
Carl Minitti, M.D. . . . . . Gibbstown

**New Jersey College of Medicine and Dentistry, Student AMA**

(Liaison requested by New Jersey Chapter—1/26/60)  
Louis F. Albright, M.D. . . . . . Spring Lake

**New Jersey Health Sciences Group**

(Membership requested by the Group 1/19/75)  
Edward G. Bourns, M.D. . . . . . Jamesburg

**New Jersey Health Sciences Group Legislative Affairs Committee**

(Liaison requested by the Group 11/16/75)  
Daniel J. O'Regan, M.D., *Chairman*  
*Council on Legislation* . . . . . Jersey City

**Nurses' Association, Joint Practice Committee with the  
New Jersey State**

(Established by Board of Trustees—7/16/72—to clarify  
roles and functions of nursing and medicine within the  
health care delivery context, with the objective being the  
improvement of health care delivery services.)  
William J. D'Elia, M.D., *Chairman* . . . . . Spring Lake  
Joseph F. Fennelly, M.D. . . . . . Madison  
James A. Rogers, M.D. . . . . . Paterson  
Mr. Vincent A. Maressa, *Executive Director* . . . . . Trenton  
MSNJ's Executive Committee

**Nursing Facilities, Advisory Committee on Skilled**

(MSNJ representation requested by Assistant Com-  
missioner for Health Facilities, New Jersey Department of  
Health—4/30/73. The Committee will revise standards for  
licensure of skilled nursing facilities.)  
David Eckstein, M.D. . . . . . Trenton

**Nutrition Council, New Jersey**

(Liaison established by MSNJ—12/19/54)  
Howard Jacobson, M.D. . . . . . Piscataway

**Parents and Teachers, New Jersey Congress of**

(Liaison requested by MSNJ's Committee on Child  
Health—12/20/64)  
William J. Farley, M.D. . . . . . Brielle

**Pension Plan, Special Committee on**

(Established by Board—5/22/55 . . . Duties outlined in  
Section XIII of Pension Plan Agreement)  
Richard E. Lang, M.D., *Chairman, Committee on*  
*Finance and Budget* . . . . . Passaic

Frank R. Begen, M.D., *Chairman, Special Committee on*  
*House Maintenance, Staff Policies, and Personnel*  
*Relations* . . . . . Teaneck  
Rudolph C. Gering, M.D., *Treasurer* . . . . . Trenton

**Quackery, Committee on**

(Established at the request of the AMA—11/15/64)  
James S. Todd, M.D., *Chairman* . . . . . Ridgewood  
Richard B. Berlin, M.D. . . . . . Englewood  
Charles B. Norton, M.D. . . . . . Woodstown

**Radiation Protection Commission, Consultant to New Jersey**

(Nomination for appointment to Commission requested  
—7/18/65)  
Bernard M. Schnur, M.D. . . . . . Trenton

**Radiation Protection Commission, New Jersey**

(Two consultants in nuclear medicine requested by the  
Commission 11/66)  
Frank R. Schell, M.D. . . . . . Wayne  
John J. Thompson, M.D. . . . . . Caldwell

**Rehabilitation Services, Division of Vocational**

(Liaison requested by MSNJ's Committee on  
Rehabilitation—5/65)  
Daniel J. O'Regan, M.D. . . . . . Jersey City

**Resolutions, Committee on Annual Meeting**

(Established by Board of Trustees—7/18/71—to re-  
view all resolutions in advance of the annual meeting)  
James A. Rogers, M.D., *Chairman* . . . . . Paterson  
Matthew E. Boylan, M.D. . . . . . Avon-by-the-Sea  
John S. Madara, M.D. . . . . . Salem

**Safety Council, New Jersey State**

(Provided in Council bylaws)  
Frank R. Begen, M.D., *President* . . . . . Teaneck  
Elmer J. Elias, M.D., *President's*  
*Representative* . . . . . Trenton

**Selective Service System, New Jersey Chairman  
of Advisory Committee to**

(Nomination for appointment by National Advisory  
Committee requested by committee—11/19/61)  
Charles L. Cunniff, M.D. . . . . . Jersey City

**State Board of Medical Examiners**

Trustees notified of meeting dates on an alphabetical,  
rotating basis. (Per Board action 12/15/74)

**Thyroid Glands, Ad Hoc Committee To Study the Management of  
Persons with Previously Irradiated**

(Established at the request of the Radiological Society  
of New Jersey)  
David Eckstein, M.D., *Chairman* . . . . . Trenton  
Alexander Crosett, M.D. . . . . . Summit  
Elmer Grimes, M.D. . . . . . Haddonfield  
Henry Kuperman, M.D. . . . . . Irvington  
Philip J. G. Quigley, M.D. . . . . . Elizabeth

**Widows and Orphans of Medical Men of New Jersey,  
Society for Relief of**

(Liaison requested by Society—5/17/59)  
Joseph R. Jehl, M.D. . . . . . Clifton



# CLINICAL NOTE

## Warning: Spurious Elevations of Blood Lead in Micro-Puncture Techniques†

S. M. Marcus, M.D., M. M. Joselow, Ph.D.,  
R. Ziering, M.D., F. Kemp, B.S., D. Mihalovic, R.N.,  
and L. Anderson, R.N., Newark\*

It has been shown that printed media (news-papers, magazines, other) may contain significant quantities of lead.<sup>1</sup> Various paper products currently available, notably towels or napkins are often made from recycled paper. The companies who manufacture such products use de-inking processes to clean and bleach the recycled materials.<sup>2</sup> The resultant product may still contain some troublesome amounts of lead.

Failure to recognize this problem can yield erroneous values for blood lead when paper towels are used as directed in instructions given for screening for micro-sampling techniques: "after the patient's hand is washed, the helper wraps damp paper towel over the patient's hand and delivers the patient to the site of collection".<sup>3</sup>

Recently, we observed what appeared to be inordinately high values for blood lead in children who were asymptomatic, and in whom FEP levels were too often inconsistent with their blood lead levels. The appearance of unexpectedly high values of blood lead coincided with the change in paper toweling used in following the above-cited directions. Analysis of the older toweling (115 towel, Scott Paper Co. Lyndhurst, N.J.) indicated that it contained 1/5 of the lead content of the newer toweling (Professional Service Towels, Marcal Paper

Mills, Elmwood Park, New Jersey). The latter was made from 60 percent "high quality" recycled material.

The Marcal Towel contained approximately five ppm lead. Normal blood lead values are in the range of less than 0.4 ppm (40 ug/100 ml). It is easy to suspect that some lead from the paper could be transferred to the finger, thus giving spuriously high blood lead values.

That this was of clinical significance can be seen from the comparison of the results in the following three patients prepared with each of the two towels.

Patient	Marcal Towel	Scott Towel
A—Blood Lead	56 ug/100 ml	33 ug/100 ml
B—Blood Lead	57 ug/100 ml	24 ug/100 ml
C—Blood Lead	44 ug/100 ml	29 ug/100 ml

Other investigators have abandoned strenuous finger washing techniques when it was found that this could give erroneous high values.<sup>4</sup> We have abandoned the use of paper towel wrapping and no longer encounter inexplicable high values for blood lead.

### References

1. Joselow MM, Bogden JD: Lead content of printed media (Warning: spitballs may be hazardous to your health). *Am J Pub Health* 64:338, 1974.
2. Letter from Marcal Paper Mills.
3. Instructions from New Jersey State Department of Health Re: Micro-sampling for Blood Lead Tests, October 1976 PV:AH/469.
4. Personal Communication: JJ Chisolm MD.

†This item first appeared as a letter in *The Journal of Pediatrics* 91:164, July 1977 and is here reproduced with permission.

\*Drs. Marcus and Ziering are affiliated with the Department of Pediatrics at Newark Beth Israel Medical Center; Dr. Joselow and Mr. Kemp are from the College of Medicine and Dentistry, and Ms. Mihalovic and Ms. Anderson are associated with the Community Nursing Service of Essex and West Hudson Counties.

212th ANNUAL MEETING, ATLANTIC CITY, MAY 6-9, 1978

# LETTER TO THE JOURNAL

## A Greeting from Israel

10 July 1977

Dear Dr. Bernstein:

After 36 years as a New Jersey State Medical Society member (12 N. 27 St., Camden), I came to Israel as a tourist in August of 1974 and was offered the position of Civil Air Surgeon for the State of Israel. I enjoy reading the *State Society Journal* which has been coming regularly. I am renewing my contract next month for another two years, and appreciate the occasional visits from former colleagues in South Jersey.

You might mention in *The Journal* that if any members visit the Holy Land, I would like to

hear from them. My office is at the airport and my residence is in Jerusalem.

My wife and I enjoy the life here, and my work is extremely interesting. I am in charge of air crew licensing, accident investigation, agricultural flying, which is extensive here, and in fact we have several research projects going on. My work requires me to fly light aircraft several times a month to make inspections of airports, agricultural strips, and so on, and as a result, my hobby has finally become my vocation. My most difficult job is learning the language.

In closing, I would be happy to see our members if they are visiting this part of the world.

(signed) Milton H. Gordon, M.D.

Ministry of Transport  
Civil Aviation Administration  
P.O. Box 8, Ben Gurion Airport, Israel  
Tel. 03-971146, Ex. 240, or 02-37621

*N.B.: The above is published with the permission of Dr. Bernstein*

# ANNOUNCEMENTS

## Graduate Course in Family Practice

A continuing series of seminars in family practice, designed to inform the practicing physician of the most significant developments in the major fields of medicine, will be held every Friday morning from September 2, 1977 through August 25, 1978 at the Brookdale Hospital Medical Center in Brooklyn. The series consists of fifty hours of lectures and will cover a broad range of subjects: gastroenterology, hematology, neonatology, radiology, cardiac arrhythmias and cardiovascular surgery, head and neck problems, genetics, infectious diseases, oral pathology, adolescent medicine, nephrology, general surgery, urology, orthopedics, and internal medicine. Fifty credit hours in

Category I of the AMA Physician's Recognition Award will be given for attendance. The program also is approved by the American Academy of Family Practice for 50 hours of prescribed credit. Tuition is \$200. For additional information please communicate with William Mackler, M.D., The Brookdale Hospital Medical Center, Office of Continuing Education, Linden Boulevard at Brookdale Plaza, Brooklyn, New York 11212.

## Computer Medicine Clinics

Cosponsored by the Society for Computer Medicine and the office of Graduate and Continuing Education of Yale University School of Medicine, a three-day course (September 19 to 21)

will be offered for practicing physicians, nurses, administrators, and others interested in a basic introduction to the use of computers in patient care. No prior computer experience is necessary. The course offers fundamental ideas about the computer and systems, discusses a wide range of applications in the office and hospital, and concludes with workshops. The program is acceptable for 15 credit hours in Category I of the AMA Physician's Recognition Award, and the same number of elective credit hours for the American Academy of Family Physicians. Sessions will convene at the Sheraton-Park Plaza Hotel in New Haven, Connecticut. For further information please communicate with Michael A. Jenkin, M.D., Society for Computer Medicine, 5100 Edina Industrial Boulevard, Suite 231F, Edina, Minnesota 55435.

### **Seminar on Pediatric Nutrition**

The Children's Hospital of Philadelphia has announced a seminar on "Nutrition in the Pediatric Population" to be held September 30 and October 1 at the hospital. The program will include case presentations, didactic lectures, and panel discussions. A fee will be charged; application has been made for AMA Category I credit. For additional information please communicate with Patrick S. Pasquariello, Jr., M.D., c/o The Children's Hospital of Philadelphia, 34th Street and Civic Center Boulevard, Philadelphia 19104.

### **"Is Anatomy Destiny?"**

An analysis of the similarities and differences in men and women, entitled "Is Anatomy Destiny?" is the subject of the 17th Annual Symposium of the Carrier Clinic Foundation to be held October 11 and 12 at the Foundation headquarters in Belle Mead. Topics include genetic and endocrine factors, physiological and attitudinal similarities and differences, developmental determinants of sexuality, growing up male in America, growing up female in America, rape, and others. Eleven and one-half hours will be awarded in Category I of the AMA Physician's Recognition Award. For information, please communicate with A. Arthur Sugerman, M.D., Director of Research, Carrier Clinic Foundation, Belle Mead, New Jersey 08502.

### **Starr Symposium on Congestive Heart Failure**

In honor of Isaac Starr, M.D., Emeritus Professor at the University of Pennsylvania, the University of Pennsylvania School of Medicine will present the Starr Symposium on "The Failing Heart" from October 12 to 14 in Philadelphia. As the first major lecture series and conference on the "state of the art" in congestive heart failure to be held for several years, the Starr Symposium will begin with a reception on the first night and continue for two and a half days with fifteen hours of lectures by national cardiologic experts. The program has been approved for 15 credit hours in Category I of the AMA Physician's Recognition Award. For additional information please communicate with Dr. Alfred P. Fishman, Cardiovascular-Pulmonary Division, Hospital of the University of Pennsylvania, 36th and Spruce Streets, Philadelphia, Pennsylvania 19104.

### **Genetics for the Clinician**

Under the sponsorship of the Morristown Memorial Hospital a symposium on "Genetics for the Clinician" will be held on Saturday morning, October 15 at the hospital. Topics include evaluation and diagnosis of genetic disease, prenatal diagnosis and genetic counseling, and screening for genetic disease, followed by a panel discussion on the topic "Genetic Counseling—What's Available in New Jersey." Registration fee is \$5. Luncheon is available at the hospital cafeteria. Application has been made for AMA Category I credit. For further information and registration please communicate with Stephen F. Wang, M.D., Chairman, Department of Pediatrics, Morristown Memorial Hospital, 100 Madison Avenue, Morristown 07960.

### **Adult Life Development**

On October 27 and 28 the Fifth Annual Clinical Conference of Friends Hospital, Philadelphia, cosponsored by the Department of Mental Health Sciences of Hahnemann Medical College, will present a program entitled "Adult Life Development: Predictable Crises and Clinical Management." The conference will



focus on diverse phenomena of adult life, centered around the individual adult's response to difficulties encountered in various stages of development—both normal concepts and deviant sequelae and their management will be addressed. Morning and afternoon sessions will be held at the hospital and dinner will be served on the evening of October 27 at the Marriott Motor Hotel. The dinner speaker, whose topic is "The Crucial Transition: Adolescent to Adult," will be the Sterling Professor of Psychiatry, Yale University School of Medicine, Theodore Lidz, M.D. Registration fee is \$85 and includes the two-day conference, luncheons, and the dinner on Thursday evening. Category I credit of the AMA Physician's Recognition Award will be given. For additional information please communicate with Mrs. Mary Foley, Friends Hospital, Roosevelt Boulevard and Adams Avenue, Philadelphia 19124.

#### **Seminar on Head and Neck Tumors**

The 5th W. Franklin Keim Memorial Seminar on Management of Head and Neck Tumors will be held November 10 to 12 at the Newark Eye and Ear Infirmary under the sponsorship of the New Jersey Medical School and the United Hospitals Medical Center. The topics, in the form of lectures, panel discussions, and open questions, will include "Immune Response to Cancer," "Immunotherapy," "Multidisciplinary Approach to Head and Neck Cancers," "Neurogenic Tumors of Head and Neck," "Vascular Tumors of Head and Neck," and "Post-laryngectomy Rehabilitation." Registration fee is \$150 (\$50 for residents). Lodging accommodations may be made at the Holiday Inn in East Orange. The program has been approved for 18 credit hours in Category I of the AMA Physician's Recognition Award. For additional information, please communicate with Dr. Ki Han, Newark Eye and Ear Infirmary, 15 South 9th Street, Newark (201) 268-8130.

#### **Pediatric Dermatology Seminar**

From February 23 to 26, 1978 a three-day pediatric dermatology seminar, sponsored by St. Francis Hospital, Miami, Florida, will convene in Miami Beach, Florida. The course is

designed to review the most recent advances in skin diseases of children. The format will consist of 45-minute lectures by an outstanding faculty of university, medical-school-affiliated professors followed by 30-minute question and discussion periods. Continuing medical education credit (12 hours) will be awarded. Tuition is \$150 (\$100 for residents and interns). The program will be followed by a one-week flight and cruise to the Caribbean and South America. Daily lectures and discussions will be continued for six days on this trip. For further information write to Guinter Kahn, M.D., 16800 NW Second Avenue, Suite 401, North Miami Beach, Florida 33169.

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#### **Society for Computer Medicine**

The Society for Computer Medicine, which was organized in 1971 and held its first conference in Chicago in November of that year with 90 some physicians in attendance, is dedicated to a better understanding of the health-care system and the application of computers to improve its functions. The majority of its members are practicing physicians, but included also are data processing professionals, administrative nurses, medical record administrators, and others. In March of 1976 the society was authorized by the American Medical Association to issue Category I CME credits to physicians. The American Medical Records Association also has authorized credits from that Society.

Typical of the problems of the Society's concern is the lack of a standard medical language and the establishment of an ethical health data center to protect patients' rights while facilitating effective use of the data base for bona fide medical purposes. The Society also participates in the newly developing Biomedical Computing Technology Information Center which, it is anticipated, will be an important clearing house of information on the use of computers in the future. The basic membership fee is \$50 (\$25 for students). Information may be obtained from the Society for Computer Medicine, 5100 Edina Industrial Boulevard, Suite 231F, Edina, Minnesota 55435.

# MEETINGS OF MEDICAL INTEREST

This listing is compiled through the cooperation of the Committee on Medical Education of The Medical Society of New Jersey, the Academy of Medicine of New Jersey, the New Jersey Chapter of the American Academy of Family Physicians, and the Office of Continuing Medical Education of the College of Medicine and Dentistry of New Jersey. For information on accreditation, please contact the sponsoring organization(s), indicated by italics—last line of each item.

Sept.

- 14 **Current Concepts of Gout**
- 21 **The Ailing A-V Junction**
- 28 **Abnormal Hemoglobins in Diabetes**  
9:30-11 a.m. — Bergen Pines County Hospital  
(*Bergen Pines County Hospital and AMNJ*)
- 14 **Alcoholism**  
3:15 p.m. — Fair Oaks Hospital, Summit  
(*AMNJ and AAFP*)
- 14 **Transfusion Reactions and Treatments**  
1-2 p.m. — VA Hospital, Lyons  
(*VA Hospital, Lyons and AMNJ*)
- 15 **Body Defenses in the Inflammatory Reaction**
- 29 **Pediatric Pulmonary Conference**  
11 a.m.-12 noon — Children's Hospital of Newark  
(*Children's Hospital of Newark and AMNJ*)
- 15- **Third Memorial Ignatz Semmelweis Seminar**
- 18 **Chalfonte/Haddon Hall, Atlantic City**  
(*CMDNJ, AMNJ and AAFP*)
- 15 **Newer Concepts in Total Parenteral Nutrition**  
5-6:30 p.m. — Somerset Hospital, Somerville  
(*Somerset Hospital and AMNJ*)
- 15 **Antibiotics in Renal Insufficiency**
- 22 **Infections in Compromised Hosts**
- 29 **Dilemma of Chronic Hepatitis**  
3:30-4:30 p.m. — Burlington Co. Memorial Hospital, Mount Holly  
(*Burlington Co. Memorial Hospital*)
- 16 **Peptic Ulcer**  
11:00 a.m.-12 noon — Ciba-Geigy Pharmaceuticals Div., Summit  
(*Ciba-Geigy and AMNJ*)
- 16 **Proper Use of Antibiotics**  
12 noon — Freehold Area Hospital  
(*AMNJ and AAFP*)
- 19 **Proper Use of Antibiotics in Surgery**  
12 noon — Hospital Center at Orange  
(*AMNJ and AAFP*)
- 19 **Neuroscience Conferences**
- 26 **11:30 a.m.-12:30 p.m. — Bergen Pines County Hospital, Paramus**  
(*Bergen Pines County Hospital and AMNJ*)
- 20 **Depression**  
5:30-6:30 p.m. — St. Mary's Hospital, Orange  
(*St. Mary's Hospital and AMNJ*)

- 20 **Current Chemotherapy**  
8:30 p.m. — Marriott, Saddle Brook  
(*AMNJ and AAFP*)
- 20 **Alcoholism**  
12 noon — St. Mary's Hospital, Orange  
(*AMNJ and AAFP*)
- 20 **Corticosteroid Therapy**  
8 p.m. — Paul Kimball Hospital, Lakewood  
(*AMNJ and AAFP*)
- 20 **Northern Regional Chest Conferences**  
7:30-9:30 p.m. — Morristown Memorial Hospital  
(*New Jersey Thoracic Society and AMNJ*)
- 13 **Venereal Disease**
- 20 **Hypertension Clinics**
- 27 **Treatment of Hypertension**  
9-10 a.m. — Holy Name Hospital, Teaneck  
(*Holy Name Hospital and AMNJ*)
- 20 **Mycoses Fungoides**  
8-10 p.m. — Schering Corporation, Kenilworth  
(*New Jersey Dermatological Society and AMNJ*)
- 20 **Diabetes in the Pediatric Age Group**  
8-10 p.m. — Englewood Hospital  
(*Pediatricians of Bergen County and AMNJ*)
- 21 **Dermatology**  
11:30 a.m. — Rahway Hospital  
(*AMNJ and AAFP*)
- 21 **Cardiac Rehabilitation**  
1 p.m. — Christ Hospital  
(*AMNJ and AAFP*)
- 21 **Legal Aspects of Psychiatric Emergencies**  
1 p.m. — Trenton Psychiatric Hospital  
(*AMNJ and AAFP*)
- 21 **Common Medical Problems for Family Physicians**  
8 a.m. — S. Ocean County Hospital, Manahawkin  
(*Burlington County Memorial Hospital and AAFP*)
- 21 **Cardiology Conference**  
4-6 p.m. — Rutgers Medical School, Piscataway  
(*CMDNJ and AMNJ*)
- 21 **Internal Medicine and Therapeutics**  
9-11 a.m. — Middlesex General Hospital, New Brunswick  
(*Middlesex General Hospital, AMNJ, and AAFP*)
- 21 **Proliferative Retinopathy**  
5-8:30 p.m. — Hunterdon Medical Center, Flemington  
(*Hunterdon Medical Center and AMNJ*)

- 21 **The Ostomy and the Ostomate**  
8:30 a.m.-4:30 p.m. — Coachman Inn, Cranford  
(*Stoma Care Center, Montclair and AMNJ*)
- 23 **Coronary Artery Disease**  
12:30 p.m. — Hamilton Hospital, Trenton  
(*AMNJ and AAFP*)
- 23 **Psychotherapy**  
8-10:30 p.m. — The Manor, West Orange  
(*N.J. Psychiatric Association and AMNJ*)
- 24 **Dedication of New Department of Surgery**  
8:30 a.m.-12:45 p.m. — N.J. Medical School, Newark  
(*CMDNJ and AMNJ*)
- 26 **The Violent Patient**  
8 p.m. — Warren Hospital, Phillipsburg  
(*AMNJ and AAFP*)
- 27 **Reconstructive Hand Surgery**  
8-10 p.m. — Englewood Men's Club, Englewood  
(*Englewood Surgical Society and AMNJ*)
- 27 **Adolescent Sexuality**  
8-10 p.m. — Ramada Inn, Clark  
(*Am. Academy Pediatrics, N.J. Chapter and AMNJ*)
- 28 **Drug Addiction**  
3:15 p.m. — Fair Oaks Hospital, Summit  
(*AMNJ and AAFP*)
- 28 **Occupational Medicine**  
1-5 p.m. — Sheraton Inn-Newark Airport, Elizabeth  
(*CMDNJ and AAFP*)
- 28 **Burn Care**  
9 a.m.-4 p.m. — Holiday Inn, Saddle Brook  
(*N.J. Committee on Trauma-ACOG and AMNJ*)
- 28 **Deinstitutionalization**  
1:30-3:30 p.m. — Trenton Psychiatric Hospital  
(*Sponsored by Trenton Psychiatric Hospital and AMNJ*)
- 28 **Occupational Medicine**  
1-5:30 p.m. — Sheraton Inn-Newark Airport, Elizabeth  
(*Rutgers Medical School and AMNJ*)
- 28 **I.V. Hyperalimentation**  
1-3 p.m. — Christ Hospital, Jersey City  
(*Christ Hospital, AMNJ, and AAFP*)
- 29-30 **Annual Meeting** — N.J. Orthopaedic Society
- Oct. 1 **Mullet Bay, St. Maarten**  
(*N.J. Orthopaedic Society and AMNJ*)
- 30 **Brush Border Membrane Disease and Malabsorption**  
9 a.m. — St. Francis Medical Center, Trenton  
(*St. Francis Medical Center*)
- Oct.
  - 1 **Surgical Symposium**  
9:30 a.m.-1 p.m. — Newark Beth Israel Medical Center  
(*Newark Beth Israel Medical Center and AMNJ*)
  - 3 **Neuroscience Conferences**
    - 17 11:30 a.m.-12:30 p.m. — Bergen Pines County Hospital,
    - 24 Paramus
    - 31 (*Bergen Pines County Hospital and AMNJ*)
  - 3 **Pre-Hospital Coronary Care**  
8 p.m. — Community Memorial Hospital, Toms River  
(*AMNJ and AAFP*)
  - 3 **Psychiatric Seminar**  
8-10 p.m. — 9 Marquette Rd., Upper Montclair  
(*Essex Psychiatric Seminar and AMNJ*)
  - 4 **Community Medicine**  
9:30-10:30 a.m. — Overlook Hospital, Summit  
(*Overlook Hospital and AAFP*)
  - 4 **Treatment of Hypertension Diabetes**
    - 18 9-10 a.m. — Holy Name Hospital, Teaneck  
(*Holy Name Hospital and AMNJ*)
  - 4 **Infectious Disease**  
11 a.m. — Greystone Park Psychiatric Hospital  
(*AMNJ and AAFP*)
  - 4 **Clinical Immunology**  
9 a.m. — Freehold Area Hospital  
(*AMNJ and AAFP*)
  - 5 **Cardiology Conferences**
    - 19 4-6 p.m. — Rutgers Medical School, Piscataway  
(*CMDNJ-Rutgers Medical School and AMNJ*)
  - 5 **Psychosomatics**
    - 12 **Q Waves: Their Clinical Implication**
    - 19 **Thromboembolism Disease**
    - 26 **Clinical Pathology Conference**  
9:30-11 a.m. — Bergen Pines County Hospital  
(*Bergen Pines County Hospital and AMNJ*)
  - 5 **Clinical Immunology**  
1 p.m. — Christ Hospital  
(*AMNJ and AAFP*)
  - 5 **Multidisciplinary Approach to Cancer**
    - 12 2-6 p.m. — Newark Beth Israel Medical Center,
    - 19 Newark
    - 26 (*Newark Beth Israel Medical Center and AMNJ*)
  - 5 **Internal Medicine and Therapeutics**
    - 12 9-11 a.m. — Middlesex General Hospital,
    - 19 New Brunswick
    - 26 (*Middlesex General Hospital and AMNJ*)
  - 6 **Adult Respiratory Distress Syndrome**
    - 13 **Difficult Upper Intestinal Bleeding**
    - 20 **Non-Hodgkin's Lymphomas — Part I**
    - 27 **Non-Hodgkin's Lymphomas — Part II**  
3:30-4:30 p.m. — Burlington Co. Memorial Hospital,  
Mount Holly  
(*Burlington Co. Memorial Hospital*)
  - 6 **Pediatric Allergy Course**
    - 13 11 a.m.-12 noon — Children's Hospital of Newark
    - 20 (*Children's Hospital of Newark and AMNJ*)
    - 27



- 6 **Infectious Disease Course**  
8:30-9:30 a.m. — Somerset Hospital, Somerville  
(*Somerset Hospital and AMNJ*)
- 7 **Bleeding Diseases**  
8:30 a.m. — United Hospitals of Newark  
(*AMNJ and AAFP*)
- 7-9 **Tenth Annual Cardiovascular Conference**  
Chalfonte-Haddon Hall, Atlantic City  
(*American Heart Association, N.J. Affiliate, Inc. and AMNJ*)
- 9 **Sexually Transmitted Diseases**  
10 a.m.-4:30 p.m. — Sheraton, Hasbrouck Heights  
(*Rutgers Medical School and AMNJ*)
- 11 **Psychiatric Case Conference**  
18 7:30-9:30 a.m. — Trenton Psychiatric Hospital  
25 (*Trenton Psychiatric Hospital and AMNJ*)
- 11 **Annual Symposium — Is Anatomy Destiny?**  
1:30 p.m.-5 p.m. — Carrier Clinic, Belle Mead  
(*Carrier Clinic and AMNJ*)
- 11 **Low Back Pain**  
8 p.m. — Paul Kimball Hospital, Lakewood  
(*AMNJ and AAFP*)
- 11 **Medical Humanism — Hospital Ethics**  
9 p.m. — Bayonne Hospital  
(*AMNJ & AAFP*)
- 12 **Dreams in Psychotherapy**  
8:30-10:30 p.m. — Guido's Restaurant, Hackensack  
(*North Jersey Psychiatric Society and AMNJ*)
- 12 **Hyperlipidemia**  
1-3 p.m. — Christ Hospital, Jersey City  
(*Christ Hospital, AMNJ and AAFP*)
- 12 **Proper Use of Antibiotics**  
1:30 p.m. — John E. Runnells Hospital, Berkeley Heights  
(*AMNJ and AAFP*)
- 12 **Psychiatric Aspects of Endocrinology**  
3:15 p.m. — Fair Oaks Hospital  
(*AMNJ and AAFP*)
- 12 **Endocrine Hypertension: Update 1977**  
1-2:30 p.m. — VA Hospital, Lyons  
(*VA Hospital and AMNJ*)
- 12 **Degenerative Diseases of Old Age**  
9 a.m.-4:30 p.m. — VA Hospital, East Orange  
(*VA Hospital and AMNJ*)
- 13 **Atrial Myxoma**  
8-9 p.m. — Deborah Heart and Lung Center, Browns Mills  
(*Burlington County Medical Society and AMNJ*)
- 13 **High Risk Obstetrics**  
12 noon-1 p.m. — St. Mary's Hospital, Orange  
(*St. Mary's Hospital and AMNJ*)
- 14 **Preservation of Ischemic Myocardium**  
11 a.m.-12 noon — Ciba-Geigy, Pharmaceuticals Div., Summit  
(*Ciba-Geigy and AMNJ*)
- 15 **Genetics for the Clinician**  
9 a.m.-1 p.m. — Morristown Memorial Hospital  
(*Morristown Memorial Hospital and AMNJ*)
- 17 **Current Treatment of Burns**  
12 noon — Hospital Center at Orange  
(*AMNJ and AAFP*)
- 18 **Coronary Artery Disease**  
12 noon — St. Mary's Hospital, Orange  
(*AMNJ and AAFP*)
- 18 **Northern Regional Chest Conferences**  
7:30-9:30 p.m. — St. Michael's Hospital, Newark  
(*New Jersey Thoracic Society and AMNJ*)
- 18- **AMA Regional CME Program**  
19 Hershey Motor Lodge, Hershey, Pa.  
(*Hahnemann, Jefferson, Medical College of Pa., CMDNJ, Howard, Penn State, Rutgers, Temple, Univ. of Pa., Univ. of Pittsburgh, Pa. Medical Society*)
- 19 **Common Medical Problems for the Family Physician**  
8 a.m. — S. Ocean County Hospital, Manahawkin  
(*Burlington County Memorial Hospital and AAFP*)
- 19 **The Suicidal Patient**  
1 p.m. — Trenton Psychiatric Hospital  
(*AMNJ and AAFP*)
- 19 **Hypovolemia, Hypovolemic Shock in the Neonate**  
2-9 p.m. — Ramada Inn, Rochelle Park  
(*St. Joseph's Hospital, Paterson and AMNJ*)
- 19 **Acute Renal Failure**  
1-3 p.m. — Christ Hospital, Jersey City  
(*Christ Hospital and AMNJ*)
- 19 **Trends in Cardiology**  
10 a.m.-noon and 2:15-4:30 p.m. — Watchung View Inn, Bridgewater  
(*Rutgers Medical School, Raritan Valley Hospital, and AMNJ*)
- 19 **Updating Peripheral Neuropathy**  
1-2 p.m. — VA Hospital, Lyons  
(*VA Hospital, Lyons, and AMNJ*)
- 20 **Viral Etiology of Cancer**  
1:45-5:30 p.m. — Drew University, Madison  
(*Ciba-Geigy and AMNJ*)
- 20 **Management of Patient with Diarrhea**  
5-6:30 p.m. — Somerset Hospital, Somerville  
(*Somerset Hospital and AMNJ*)
- 20 **Assertive Training**  
9:30 a.m.-3:30 p.m. — Trenton Psychiatric Hospital  
(*Trenton Psychiatric Hospital and AMNJ*)

- 21 Cardiac Rehabilitation**  
5 p.m. — Holiday Inn, Deepwater  
(*AMNJ and AAFP*)
- 24 Outpatient Management — Urology**  
8 p.m. — Warren Hospital  
(*AMNJ and AAFP*)
- 25 Pulmonary Infiltrates and Allergy in the Surgical Patient**  
8-10 p.m. — Englewood Men's Club  
(*Englewood Surgical Society and AMNJ*)
- 25 Clinical Pathological Conference**  
1-2 p.m. — Trenton Psychiatric Hospital  
(*Trenton Psychiatric Hospital and AMNJ*)
- 26 The American Diabetes Association**  
All Day — Morristown Memorial Hospital  
(*Morristown Memorial Hospital, AMNJ, and American Diabetes Assoc.*)
- 26 Clinical Hypnosis**  
1-5 p.m. — Ramada Inn, Clark  
(*Rutgers Medical School and AMNJ*)
- 26 Appendicitis in the Adolescent Patient**  
1 p.m. — Christ Hospital, Jersey City  
(*Christ Hospital*)
- 26 Bleeding Diseases**  
11:30 a.m. — Rahway Hospital  
(*AMNJ and AAFP*)
- 26 Medical/Legal Aspects of Medicine and Surgery**  
3:15 p.m. — Fair Oaks Hospital, Summit  
(*AMNJ and AAFP*)
- 27 Advances in Newborn Infections**  
9:30 a.m. — Newark Beth Israel Medical Center  
(*AMNJ and AAFP*)
- 27 Retropubic Prostatectomy**  
12 noon-1 p.m. — St. Mary's Hospital, Orange  
(*St. Mary's Hospital and AMNJ*)
- 28 Anti-Psychotic Medications**  
1-2 p.m. — VA Hospital, Lyons  
(*VA Hospital, Lyons, and AMNJ*)
- 28 Proper Use of Antibiotics**  
12:30 p.m. — Hamilton Hospital, Trenton  
(*AMNJ and AAFP*)
- 29 Annual Respiratory Care Symposium**  
9 a.m.-1 p.m. — Rutgers Medical School, Piscataway  
(*N.J. State Society of Anesthesiologists and AMNJ*)
- Nov.
- 1 Community Medicine**  
9:30-10:30 a.m. — Overlook Hospital, Summit  
(*Overlook Hospital and AAFP*)
- 1 Dermatology**  
9 a.m. — Freehold Area Hospital  
(*AMNJ and AAFP*)
- 2 Diabetes**  
1 p.m. — Christ Hospital  
(*AMNJ and AAFP*)
- 2 Multidisciplinary Approach to Cancer**  
9 2-4 p.m. — Newark Beth Israel Medical Center  
16 (*Newark Beth Israel Medical Center and AMNJ*)  
23  
30
- 2 Clinical Hypnosis**  
9 1-5 p.m. — Ramada Inn, Clark  
16 (*Rutgers Medical School and AMNJ*)
- 2 Internal Medicine and Therapeutics**  
9 9-11 a.m. — Middlesex General Hospital,  
16 New Brunswick  
23 (*Middlesex General Hospital and AMNJ*)  
30
- 2 New Non-Steroidal Anti-Inflammatory Drugs**  
9 To be announced  
16 Environmental Cancer  
23 Galactorrhea  
30 Host Factors—Influencing the Impact of Disease  
9:30-11:30 a.m. — Bergen Pines County Hospital  
(*Bergen Pines County Hospital and AMNJ*)
- 2 Cardiology Conferences**  
16 4-6 p.m. — Rutgers Medical School, Piscataway  
(*CMDNJ and AMNJ*)
- 2 Chronic Pain — A Medical Nemesis**  
8-10 p.m. — Seton Hall University, So. Orange  
(*Mental Health Assoc. of Essex County and AMNJ*)
- 3 Pediatric Allergy Course**  
10 11 a.m.-12 noon — Children's Hospital of Newark  
17 (*Children's Hospital of Newark and AMNJ*)  
24
- 3 Infectious Disease Course**  
8:30-9:30 a.m. — Somerset Hospital, Somerville  
(*Somerset Hospital and AMNJ*)
- 3 Outpatient Management of Tuberculosis**  
11 a.m. — Greystone Park Psychiatric Hospital  
(*AMNJ and AAFP*)
- 3 Acid Base Balance**  
10 Heart Failure  
17 Ovarian Carcinoma  
3:30-4:30 p.m. — Burlington County Memorial Hospi-  
tal, Mount Holly  
(*Burlington Co. Memorial Hospital*)
- 4 Laboratory Interpretations**  
8:30 a.m. — United Hospitals of Newark  
(*AMNJ and AAFP*)
- 4 Gastrointestinal Hormone Assay**  
12 noon-1 p.m. — St. Mary's Hospital, Orange  
(*St. Mary's Hospital and AMNJ*)
- 7 Psychiatric Seminar**  
8-10 p.m. — 4 Garden Place, Nutley  
(*Essex Psychiatric Seminar and AMNJ*)

- 7 **Neuroscience Conferences**
- 14 11:30 a.m.-12:30 p.m. — Bergen Pines County Hospital, Paramus
- 21 **Paramus**
- 28 (*Bergen Pines County Hospital and AMNJ*)
- 8 **Effect of Medications on Laboratory Tests**
- 8 p.m. — Paul Kimball Hospital, Lakewood
- (*AMNJ and AAFP*)
- 8 **Medical Humanism: Hospital Ethics**
- 12 noon — Hospital Center at Orange
- (*AMNJ and AAFP*)
- 9 **Echocardiography**
- 1 p.m. — Christ Hospital, Jersey City
- (*Christ Hospital*)
- 9 **Cardiac Arrhythmias**
- 1:30 p.m. — John E. Runnells Hospital, Berkeley Heights
- (*AMNJ and AAFP*)
- 9 **Acute Renal Failure**
- 11:30 a.m. — Rahway Hospital
- (*AMNJ and AAFP*)
- 9 **Malpractice**
- 3:15 p.m. — Fair Oaks Hospital
- (*AMNJ and AAFP*)
- 9 **Rapid Control of Violent Behavior**
- 1:30-3:30 p.m. — Trenton Psychiatric Hospital
- (*Trenton Psychiatric Hospital and AMNJ*)
- 12 **Family Therapy**
- 9 a.m.-5p.m. — Holiday Inn, Livingston
- (*N.J. Center for Family Studies and AMNJ*)
- 15 **Northern Regional Chest Conferences**
- 7:30-9:30 p.m. — Martland Hospital, Newark
- (*New Jersey Thoracic Society and AMNJ*)
- 15 **Diabetes**
- 12 noon — St. Mary's Hospital, Orange
- (*AMNJ and AAFP*)
- 16 **Management of Acute Drug Abuse Emergencies**
- 1 p.m. — Trenton Psychiatric Hospital
- (*AMNJ and AAFP*)
- 16 **Common Medical Problems for the Family Physician**
- 8 a.m. — S. Ocean County Hospital, Manahawkin
- (*Burlington County Memorial Hospital and AMNJ*)
- 16 **To be announced**
- 1 p.m. — Christ Hospital, Jersey City
- (*Christ Hospital*)
- 17 **Sexual Incompatibility — Causes and Cures**
- 5-6:30 p.m. — Somerset Hospital, Somerville
- (*Somerset Hospital and AMNJ*)
- 17 **Assertive Training**
- 9:30 a.m.-3:30 p.m. — Trenton Psychiatric Hospital
- (*Trenton Psychiatric Hospital and AMNJ*)
- 18 **Cardiac Rehabilitation**
- 12 noon — Freehold Area Hospital
- (*AMNJ and AAFP*)
- 23 **Headache**
- 3:15 p.m. — Fair Oaks Hospital, Summit
- (*AMNJ and AAFP*)
- 25 **G.I. Bleeding**
- 12:30 p.m. — Hamilton Hospital, Trenton
- (*AMNJ and AAFP*)
- 28 **Intra-Aortic Balloon Pumping**
- 8 p.m. — Warren Hospital, Phillipsburg
- (*AMNJ and AAFP*)
- 29 **Clinical Pathological Conferences**
- 1-2 p.m. — Trenton Psychiatric Hospital
- (*Trenton Psychiatric Hospital and AMNJ*)
- 29 **The Psychiatrist in Community Mental Health Center**
- 1:30-3:30 p.m. — Trenton Psychiatric Hospital
- (*Trenton Psychiatric Hospital and AMNJ*)
- 30 **Hypertension II**
- 1-3 p.m. — Christ Hospital, Jersey City
- (*Christ Hospital and AMNJ*)
- 30 **Fall Refresher Course**
- 9:15 a.m.-4:45 p.m. — John F. Kennedy Medical Center, Edison
- (*AAFP and AMNJ*)
- 30 **Arthritis**
- 3 p.m. — Ancora Psychiatric Hospital, Hammonton
- (*AMNJ and AAFP*)
- Dec.
- 1 **Pediatric Allergy Course**
- 8 11 a.m.-12 noon — Children's Hospital of Newark
- 15 (*Children's Hospital of Newark and AMNJ*)
- 22
- 1 **Infectious Disease Course**
- 8:30-9:30 a.m. — Somerset Hospital, Somerville
- (*Somerset Hospital and AMNJ*)
- 1 **Bleeding Diseases**
- 11 a.m. — Greystone Park Psychiatric Hospital
- (*AMNJ and AAFP*)
- 1 **Inflammatory Bowel Disease**
- 8 **Blood Transfusions**
- 15 **Syphilis and the Clinician**
- 3:30-4:30 p.m. — Burlington Co. Memorial Hospital, Mount Holly
- (*Burlington Co. Memorial Hospital*)
- 2 **Thanatology**
- 8:30 a.m. — United Hospitals of Newark
- (*AMNJ and AAFP*)
- 2 **Diabetes**
- 12 noon — Freehold Area Hospital
- (*AMNJ and AAFP*)
- 5 **Neuroscience Conference**
- 12 11:30 a.m.-12:30 p.m. — Bergen Pines County Hospital,
- 19 Paramus
- (*Bergen Pines County Hospital and AMNJ*)



- 5 **Bleeding Diseases**  
11 a.m.—Community Memorial Hospital, Toms River  
(*AMNJ and AAFP*)
  - 5 **Psychiatric Seminar**  
8-10 p.m.—192 Chittenden Rd., Clifton  
(*Essex Psychiatric Seminar and AMNJ*)
  - 6 **Community Medicine**  
9:30-10:30 a.m.—Overlook Hospital, Summit  
(*Overlook Hospital and AAFP*)
  - 6 **Congenital Diseases**  
9 a.m.—Freehold Area Hospital  
(*AMNJ and AAFP*)
  - 7 **Pitfalls of Laboratory Screening**
  - 14 **Polycythemia Vera**
  - 21 **Aspirin for the Limping Brain**
  - 28 **Clinical Pathology Conference**  
9:30-11:30 a.m.—Bergen Pines County Hospital, Paramus  
(*AMNJ and AAFP*)
  - 7 **Cardiology Conferences**  
4-6 p.m.—Rutgers Medical School, Piscataway  
(*CMDNJ and AMNJ*)
  - 7 **Cerebral Vascular Accident**  
3:15 p.m.—Fair Oaks Hospital, Summit  
(*AMNJ and AAFP*)
  - 7 **New Methods of Endocrine Testing**  
1 p.m.—Christ Hospital, Jersey City  
(*AMNJ and AAFP*)
  - 7 **Multidisciplinary Approach to Cancer**
  - 14 **2-4 p.m.—Newark Beth Israel Medical Center**
  - 21 (*Newark Beth Israel Medical Center and AMNJ*)
  - 8 **Hard-to-Manage Diabetes**  
5-6:30 p.m.—Somerset Hospital, Somerville  
(*Somerset Hospital and AMNJ*)
  - 13 **Obesity and Hypoglycemia**  
8 p.m.—Paul Kimball Hospital  
(*AMNJ and AAFP*)
  - 13 **Medical/Legal Aspects of Medicine and Surgery**  
9 p.m.—Bayonne Hospital  
(*AMNJ and AAFP*)
  - 14 **Clinical E.E.G.**  
1 p.m.—Christ Hospital, Jersey City  
(*Christ Hospital*)
  - 14 **Psychopharmacology**  
1:30-3:30 p.m.—Trenton Psychiatric Hospital  
(*Trenton Psychiatric Hospital and AMNJ*)
  - 16 **Management of Hepatitis**  
5 p.m.—Salem County Medical Society  
(*AMNJ and AAFP*)
  - 19 **Surgical Management of Ulcerative Colitis**  
12 noon—Hospital Center at Orange  
(*AMNJ and AAFP*)
  - 20 **Disseminated Intravascular Coagulation**  
12 noon—St. Mary's Hospital, Orange  
(*AMNJ and AAFP*)
  - 21 **Common Medical Problems for the Family Physician**  
8 a.m.—S. Ocean County Hospital, Manahawkin  
(*Burlington County Memorial Hospital and AAFP*)
  - 21 **Suicidology**  
3:15 p.m.—Fair Oaks Hospital, Summit  
(*AMNJ and AAFP*)
  - 27 **Clinical Pathological Conference**  
1-2 p.m.—Trenton Psychiatric Hospital  
(*Trenton Psychiatric Hospital and AMNJ*)
  - 30 **Medical Care in Emergency Department**  
12:30 p.m.—Hamilton Hospital, Trenton  
(*AMNJ and AAFP*)
- Jan.
- 2 **Medical Care in Emergency Department**  
8 p.m.—Community Memorial Hospital, Toms River  
(*AMNJ and AAFP*)
  - 3 **Peripheral Vascular Disease**  
11 a.m.—Greystone Park Psychiatric Hospital  
(*AMNJ and AAFP*)
  - 4 **Advances in Medicine**
  - 11 9:30-11 a.m.—Bergen Pines County Hospital, Paramus
  - 18 (*Bergen Pines County Hospital and AMNJ*)
  - 25
  - 4 **Cardiology Conferences**
  - 18 4-6 p.m.—Rutgers Medical School, Piscataway  
(*CMDNJ and AMNJ*)
  - 4 **New Developments in Scanning**  
3:15 p.m.—Fair Oaks Hospital, Summit  
(*AMNJ and AAFP*)
  - 4 **Psychiatric Aspects of Endocrinology**  
1 p.m.—Christ Hospital, Jersey City  
(*AMNJ and AAFP*)
  - 5 **Pediatric Allergy Course**
  - 12 11 a.m.-12 noon—Children's Hospital of Newark
  - 19 (*Children's Hospital of Newark and AMNJ*)
  - 26
  - 5 **Infectious Disease Course**  
8:30-9:30 a.m.—Somerset Hospital, Somerville  
(*Somerset Hospital and AMNJ*)
  - 6 **Outpatient Management of Tuberculosis**  
8:30 a.m.—United Hospitals of Newark  
(*AMNJ and AAFP*)
  - 9 **Neuroscience Conferences**
  - 16 11:30 a.m.-12:30 p.m.—Bergen Pines County Hospital,
  - 23 Paramus
  - 30 (*Bergen Pines County Hospital and AMNJ*)
  - 10 **Arthritis**  
12 noon—Hospital Center at Orange  
(*AMNJ and AAFP*)

- 10 **Genetics**  
8 p.m. — Paul Kimball Hospital, Lakewood  
(*AMNJ and AAFP*)
  - 11 **Cerebral Vascular Disease**  
11:30 a.m. — Rahway Hospital  
(*AMNJ and AAFP*)
  - 11 **Fluid and Electrolyte Imbalance**  
1:30 p.m. — John E. Runnells Hospital, Berkeley Heights  
(*AMNJ and AAFP*)
  - 17 **Northern Regional Chest Conferences**  
7:30-9:30 p.m. — Mountainside Hospital, Montclair  
(*New Jersey Thoracic Society and AMNJ*)
  - 17 **Pulmonary Embolism**  
12 noon — St. Mary's Hospital, Orange  
(*AMNJ and AAFP*)
  - 18 **Advanced Life Support in CPR**  
1 p.m. — Trenton Psychiatric Hospital  
(*AMNJ and AAFP*)
  - 18 **Medical Humanism-Hospital Ethics**  
3:15 p.m. — Fair Oaks Hospital, Summit  
(*AMNJ and AAFP*)
  - 19 **Cellular Engineering in Medicine**  
5-6:30 p.m. — Somerset Hospital, Somerville  
(*Somerset Hospital and AMNJ*)
  - 24 **Allergy**  
8 p.m. — Warren Hospital, Phillipsburg  
(*AMNJ and AAFP*)
  - 25 **Evaluation of Hemorrhagic and Bleeding Disorders**  
1-2 p.m. — VA Hospital, Lyons  
(*VA Hospital and AMNJ*)
  - 27 **Cardiac Arrhythmias**  
12:30 p.m. — Hamilton Hospital, Trenton  
(*AMNJ and AAFP*)
- Feb.
- 1 **Cardiology Conferences**
  - 15 **4-6 p.m. — Rutgers Medical School, Piscataway**  
(*CMDNJ and AMNJ*)
  - 1 **Advances in Medicine**  
9:30-11 a.m. — Bergen Pines Hospital, Paramus  
(*Bergen Pines County Hospital and AMNJ*)
  - 1 **Cerebral Vascular Disease**  
1 p.m. — Christ Hospital, Jersey City  
(*AMNJ and AAFP*)
  - 2 **Pediatric Allergy Course**
  - 9 **11 a.m.-12 noon — Children's Hospital of Newark**  
(*Children's Hospital of Newark and AMNJ*)
  - 16
  - 23
  - 2 **Infectious Disease Course**  
8:30-9:30 a.m. — Somerset Hospital, Somerville  
(*Somerset Hospital and AMNJ*)
  - 2 **Diabetes**  
11 a.m. — Greystone Park Psychiatric Hospital  
(*AMNJ and AAFP*)
  - 3 **Proper Uses of Blood Gases**  
8:30 a.m. — United Hospitals of Newark  
(*AMNJ and AAFP*)
  - 6 **Neuroscience Conferences**
  - 13 **11:30 a.m.-12:30 p.m. — Bergen Pines County Hospital,**
  - 20 **Paramus**
  - 27 **(Bergen Pines County Hospital and AMNJ)**
  - 6 **Headache**  
8 p.m. — Community Memorial Hospital, Toms River  
(*AMNJ and AAFP*)
  - 7 **Neonatal Emergencies**  
9 a.m. — Freehold Area Hospital  
(*AMNJ and AAFP*)
  - 8 **Peripheral Vascular Disease**  
11:30 a.m. — Rahway Hospital  
1:30 p.m. — John E. Runnells Hospital, Berkeley Heights  
(*AMNJ and AAFP*)
  - 14 **Hyponitremia: Hypokalemia**  
8 p.m. — Paul Kimball Hospital, Lakewood  
(*AMNJ and AAFP*)
  - 15 **Medical Humanism-Hospital Ethics**  
1 p.m. — Trenton Psychiatric Hospital  
(*AMNJ and AAFP*)
  - 16 **Appropriate Workup for the Headache Patient**  
5-6:30 p.m. — Somerset Hospital, Somerville  
(*Somerset Hospital and AMNJ*)
  - 17 **Laboratory Interpretations**  
5 p.m. — Holiday Inn, Deepwater  
(*AMNJ and AAFP*)
  - 17 **Endocrinology**  
12 noon — Freehold Area Hospital  
(*AMNJ and AAFP*)
  - 20 **Current Surgical Techniques of Breast Cancer**  
12 noon — Hospital Center at Orange  
(*AMNJ and AAFP*)
  - 21 **Northern Regional Chest Conferences**  
7:30-9:30 p.m. — St. Barnabas Hospital, Livingston  
(*New Jersey Thoracic Society and AMNJ*)
  - 21 **Cancer of the Colon and Ovary**  
12 noon — St. Mary's Hospital, Orange  
(*AMNJ and AAFP*)
  - 24 **Carcinoma of the Breast**  
12:30 p.m. — Hamilton Hospital, Trenton  
(*AMNJ and AAFP*)
  - 28 **Drug Addiction**  
8 p.m. — Warren Hospital, Phillipsburg  
(*AMNJ and AAFP*)

## Mar.

- 1 **Advances in Medicine**
- 8 9:30-11 a.m.—Bergen Pines County Hospital, Paramus  
(*Bergen Pines County Hospital and AMNJ*)
- 15
- 22
- 29
- 1 **Cardiology Conferences**
- 15 4-6 p.m.—Rutgers Medical School, Piscataway  
(*CMDNJ and AMNJ*)
- 1 **Proper Use of Blood Gases**  
11:30 a.m.—Rahway Hospital  
(*AMNJ and AAFP*)
- 1 **Fiberoptic Bronchoscopy**  
1 p.m.—Christ Hospital  
(*AMNJ and AAFP*)
- 2 **Pediatric Allergy Course**
- 9 11 a.m.-12 noon—Children's Hospital of Newark  
(*Children's Hospital of Newark and AMNJ*)
- 16
- 23
- 30
- 2 **Immunology**  
11 a.m.—Greystone Park Psychiatric Hospital  
(*AMNJ and AAFP*)
- 2 **Infectious Disease Course**  
8:30-9:30 a.m.—Somerset Hospital, Somerville  
(*Somerset Hospital and AAFP*)
- 3 **Clinical Immunology**  
8:30 a.m.—United Hospitals of Newark  
(*AMNJ and AAFP*)
- 6 **Neuroscience Conferences**
- 13 11:30 a.m.-12:30 p.m.—Bergen Pines County Hospital,  
20 Paramus  
27 (*Bergen Pines County Hospital and AMNJ*)
- 6 **Obstructive Lung Disease**  
8 p.m.—Community Memorial Hospital, Toms River  
(*AMNJ and AAFP*)
- 14 **Cancer in New Jersey**  
8 p.m.—Paul Kimball Hospital, Lakewood  
(*AMNJ and AAFP*)
- 14 **Medical Care in Emergency Department**  
9 p.m.—Bayonne Hospital  
(*AMNJ and AAFP*)
- 14 **Medical/Legal Aspects of Medicine and Surgery**  
12 noon—Hospital Center at Orange  
(*AMNJ and AAFP*)
- 15 **Proper Use of Antibiotics**  
1 p.m.—Trenton Psychiatric Hospital  
(*AMNJ and AAFP*)
- 16 **Emotional Management in Myocardial Infarction**  
5-6:30 p.m.—Somerset Hospital, Somerville  
(*Somerset Hospital and AAFP*)
- 17 **The Violent Patient**  
5 p.m.—Holiday Inn-Deepwater  
(*AMNJ and AAFP*)

- 17 **Diagnosis of Anemic Patient**  
12 noon—Freehold Area Hospital  
(*AMNJ and AAFP*)
- 21 **Scanning**  
12 noon—St. Mary's Hospital, Orange  
(*AMNJ and AAFP*)
- 21 **Congestive Heart Failure**  
8:30 p.m.—Fair Lawn Memorial Hospital—Marriott,  
Saddlebrook  
(*AMNJ and AAFP*)
- 21 **Northern Regional Chest Conferences**  
7:30-9:30 p.m.—St. Joseph's Hospital, Paterson  
(*New Jersey Thoracic Society and AMNJ*)
- 24 **Bleeding Disorders**  
12:30 p.m.—Hamilton Hospital, Trenton  
(*AMNJ and AAFP*)
- 28 **Hepatitis**  
8 p.m.—Warren Hospital, Phillipsburg  
(*AMNJ and AAFP*)
- 29 **Cerebral Vascular Disease**  
3 p.m.—Ancora Psychiatric Hospital, Hammonton  
(*AMNJ and AAFP*)

## Apr.

- 3 **Neuroscience Conferences**
- 10 11:30 a.m.-12:30 p.m.—Bergen Pines County Hospital,  
17 Paramus  
24 (*Bergen Pines County Hospital and AMNJ*)
- 3 **Suicidology**  
8 p.m.—Community Memorial Hospital, Toms River  
(*AMNJ and AAFP*)
- 4 **New Developments in Scanning**  
11 a.m.—Greystone Park Psychiatric Hospital  
(*AMNJ and AAFP*)
- 5 **Advances in Medicine**
- 12 9:30-11 a.m.—Bergen Pines County Hospital, Paramus  
19 (*Bergen Pines County Hospital and AMNJ*)
- 26
- 5 **Cardiology Conferences**
- 19 4-6 p.m.—Rutgers Medical School, Piscataway  
(*CMDNJ and AMNJ*)
- 5 **Outpatient Management of Tuberculosis**  
11:30 a.m.—Rahway Hospital  
(*AMNJ and AAFP*)
- 5 **Suicidology**  
1 p.m.—Christ Hospital, Jersey City  
(*AMNJ and AAFP*)
- 6 **Pediatric Allergy Course**
- 13 11 a.m.-12 noon—Children's Hospital of Newark  
20 (*Children's Hospital of Newark and AMNJ*)
- 27
- 6 **Infectious Disease Course**  
8:30-9:30 a.m.—Somerset Hospital, Somerville  
(*Somerset Hospital and AMNJ*)



- 7 **Infectious Diseases**  
8:30 a.m. — United Hospitals of Newark  
(*AMNJ and AAFP*)
  - 8 **Third Annual Orthopedic Symposium**  
Rutgers Medical School, Piscataway  
(*AMNJ and AAFP*)
  - 11 **Fluid and Electrolyte Balance**  
12 noon — Hospital Center at Orange  
(*AMNJ and AAFP*)
  - 12 **Proper Use of Blood Gases**  
1:30 p.m. — John E. Runnells Hospital, Berkeley Heights  
(*AMNJ and AAFP*)
  - 18 **Northern Regional Chest Conferences**  
7:30-9:30 p.m. — Location to be announced  
(*New Jersey Thoracic Society and AMNJ*)
  - 18 **Intra-Aortic Balloon Pumping**  
12 noon — St. Mary's Hospital, Orange  
(*AMNJ and AAFP*)
  - 19 **The Psychodynamics of Dental Practice**  
9 a.m.-4 p.m. — New Jersey Dental School, Newark  
(*AMNJ and CMDNJ*)
  - 21 **Management of Hepatitis**  
12 noon — Freehold Area Hospital  
(*AMNJ and AAFP*)
  - 25 **Medical/Legal Aspects of Medicine and Surgery**  
8 p.m. — Warren Hospital, Phillipsburg  
(*AMNJ and AAFP*)
  - 28 **Surgical Management of Inflammatory Bowel Disease**  
12:30 p.m. — Hamilton Hospital, Trenton  
(*AMNJ and AAFP*)
  - 1 **Neuroscience Conferences**  
8 11:30 a.m.-12:30 p.m. — Bergen Pines County Hospital,  
15 Paramus  
22 (*Bergen Pines County Hospital and AMNJ*)
- May
- 1 **Arthritis**  
8 p.m. — Community Memorial Hospital, Toms River  
(*AMNJ and AAFP*)
  - 2 **Thyroid Disease**  
11 a.m. — Greystone Park Psychiatric Hospital  
(*AMNJ and AAFP*)
  - 3 **Advances in Medicine**  
10 9:30-11 a.m. — Bergen Pines County Hospital,  
17 Paramus  
24 (*Bergen Pines County Hospital and AMNJ*)
  - 3 **Cardiology Conferences**  
17 4-6 p.m. — Rutgers Medical School  
(*CMDNJ and AMNJ*)
  - 3 **Medical Humanism-Hospital Ethics**  
11:30 a.m. — Rahway Hospital  
(*AMNJ and AAFP*)
- 4 **Pediatric Allergy Course**  
11 11 a.m.-12 noon — Children's Hospital of Newark  
18 (*Children's Hospital of Newark and AMNJ*)  
25
  - 4 **Infectious Diseases Course**  
8:30-9:30 a.m. — Somerset Hospital, Somerville  
(*Somerset Hospital of Newark and AMNJ*)
  - 5 **Cerebral Vascular Disease**  
8:30 a.m. — United Hospitals of Newark  
(*AMNJ and AAFP*)
  - 6- **MSNJ Annual Meeting**  
9 Holiday Inn-Howard Johnson's Regency, Atlantic City
  - 9 **Fluid and Electrolyte Imbalance**  
9 p.m. — Bayonne Hospital  
(*AMNJ and AAFP*)
  - 10 **Arthritis**  
1:30 p.m. — John E. Runnells Hospital, Berkeley Heights  
(*AMNJ and AAFP*)
  - 15 **Endotoxic/Hemorrhagic Shock**  
12 noon — Hospital Center at Orange  
(*AMNJ and AAFP*)
  - 16 **Kidney Stones**  
12 noon — St. Mary's Orange  
(*AMNJ and AAFP*)
  - 18 **Antithrombotic Therapy**  
5-6:30 p.m. — Somerset Hospital, Somerville  
(*Somerset Hospital and AMNJ*)
  - 19 **Chronic Renal Failure**  
12 noon — Freehold Area Hospital  
(*AMNJ and AAFP*)
  - 23 **Cerebral Vascular Disease**  
8 p.m. — Warren Hospital, Phillipsburg  
(*AMNJ and AAFP*)
  - 26 **Ophthalmologic Manifestations in Systemic Disease**  
12:30 p.m. — Hamilton Hospital, Trenton  
(*AMNJ and AAFP*)
  - 31 **Cardiac Arrhythmias**  
3 p.m. — Ancora Psychiatric Hospital, Hammonton  
(*AMNJ and AAFP*)
- June
- 1 **Infectious Disease Course**  
8:30-9:30 a.m. — Somerset Hospital, Somerville  
(*Somerset Hospital and AAFP*)
  - 1 **Current Radiation Therapy**  
11 a.m. — Greystone Park Psychiatric Hospital  
(*AMNJ and AAFP*)
  - 2 **Lipid Metabolism**  
8:30 a.m. — United Hospitals of Newark  
(*AMNJ and AAFP*)

- 5 **Neuroscience Conferences**
- 12 11:30 a.m.-12:30 p.m. — Bergen Pines County Hospital, Paramus
- 26 (*Bergen Pines County Hospital and AMNJ*)
  
- 5 **Thyroid Diseases**
- 8 p.m. — Community Memorial Hospital, Toms River (*AMNJ and AAFP*)
  
- 7 **Advances in Medicine**
- 14 9:30-11 a.m. — Bergen Pines County Hospital, Paramus
- 21 (*Bergen Pines County Hospital and AMNJ*)
- 28
  
- 7 **Cardiology Conferences**
- 21 4-6 p.m. — Rutgers Medical School, Piscataway (*CMDNJ and AMNJ*)
  
- 15 **Beta-Adrenergic Blocking Agent in Cardiovascular Disease**
- 5-6:30 p.m. — Somerset Hospital, Somerville (*Somerset Hospital and AMNJ*)
  
- 16 **Sports Medicine**
- 12 noon — Freehold Area Hospital (*AMNJ and AAFP*)
  
- 20 **Northern Regional Chest Conferences**
- 7:30-9:30 p.m. — Beth Israel Hospital, Newark (*New Jersey Thoracic Society and AMNJ*)
  
- 20 **Acute and Chronic Leukemia**
- 12 noon — St. Mary's Hospital, Orange (*AMNJ and AAFP*)
  
- 20 **Shock**
- 8:30 p.m. — Fair Lawn Memorial Hospital — Marriott, Saddle Brook (*AMNJ and AAFP*)
  
- 27 **Current Radiation Therapy**
- 8 p.m. — Warren Hospital, Phillipsburg (*AMNJ and AAFP*)
  
- 30 **Chronic Obstructive Lung Disease**
- 12:30 p.m. — Hamilton Hospital, Trenton (*AMNJ and AAFP*)

### The Old Helping Hand Organization

Many of the younger doctors do not know that there exists in our state a unique helping hand organization, known as the Society for the Relief of the Widows and Orphans of Medical Men in New Jersey. This organization provides immediate

financial assistance to the dependents of a deceased member. It lends money without interest to assist widows and orphans of doctors who have known adversity. For details, write to the Widows and Orphans Society, P.O. Box 904, Trenton 08605.

## OBITUARIES

### Dr. Gerard J. Alonzo

Word has been received of the death on June 22 of Gerard J. Alonzo, M.D., a member of our Passaic County Medical Society. A family practitioner from Lyndhurst, Dr. Alonzo was graduated from Rush Medical College in 1938 and took graduate training in internal medicine

at St. Joseph's Hospital in Paterson. Following this he served five years in the department of medicine of the Army of the United States. Upon discharge he returned to New Jersey to establish a practice in Passaic County. Dr. Alonzo was affiliated with Saint Barnabas Medical Center in Livingston and the Clara Maass Memorial Hospital in Belleville. He was a member of the American Geriatric Society and the Academy of Medicine of New Jersey. Dr. Alonzo was 64 years old at the time of his death.

### **Dr. Harry Arons**

Harry Arons, M.D., formerly of Elizabeth, died this past July. Born in 1907 and graduated from New York University School of Medicine in 1931, Dr. Arons pursued a career in dermatology and was board certified in that specialty. He was on the attending staff at St. Elizabeth's and Alexian Brothers' hospitals in Elizabeth and the Martland Medical Center in Newark. He was a Fellow of the American Academy of Dermatology and a member of the New Jersey Society of Dermatologists. During World War II he had served in the medical corps of the United States Army. Dr. Arons was retired and lived at Rossmoor in Jamesburg.

### **Dr. Norbert Beim**

A member of our Passaic County component, Norbert Beim, M.D., died on July 10 in Barnert Memorial Hospital after a lengthy illness. Born in Vienna at the turn of the century, Dr. Beim received his medical degree from the University of Vienna in 1937 and emigrated to the United States the following year. He practiced first in Chicago and moved to New Jersey thirty years ago. Dr. Beim was affiliated with Barnert Memorial Hospital where he had been chief of psychiatry until retirement in 1973. He had been active in obtaining federal funding for the Paterson Community Mental Health Center. Dr. Beim's avocations included photography, especially landscapes, and music, in which art he was an accomplished pianist. He was a member of the American and New Jersey Psychiatric Associations.

### **Dr. Benjamin V. Cannata**

Benjamin Victor Cannata, M.D., a member of our Middlesex County component, died on June 26. Born in 1915 and graduated from the University of Bologna (Italy), class of 1941, Dr. Cannata returned to his home community of Perth Amboy to establish a general practice with special interest in obstetrics. He had been affiliated with the Perth Amboy General Hospital and the Rehabilitation Center in North Brunswick and was a member of the Academy of Medicine of New Jersey.

### **Dr. Edgar P. Cardwell**

One of Essex County's senior members, Edgar P. Cardwell, M.D., formerly of Newark and East Orange, died this past May. Graduated from the University of Virginia School of Medicine in 1923, Dr. Cardwell followed a career in otolaryngology, becoming board certified in that specialty. He had been affiliated with the Newark Eye and Ear Infirmary, where he was chief of the department of otolaryngology, and with Presbyterian, St. Michael's, and Martland Hospitals in Newark, Orange Memorial Hospital, the Rahway Hospital, the Alexander Linn Hospital in Sussex, and the Essex County Isolation Hospital in Belleville. He was a Fellow of the American College of Surgeons and of the American Academy of Ophthalmology and Otolaryngology, and was a member of the New Jersey Society of Surgeons and of several specialty organizations in his field. Dr. Cardwell retired in 1967 and moved to Wilmington, North Carolina and more recently to Wrightsville, North Carolina. He was a 1973 recipient of MSNJ's Golden Merit Award. Dr. Cardwell was 78 years old at the time of his death.

### **Dr. Morris Flichtenfeld**

One of Hudson County's senior members, Morris Flichtenfeld, M.D., of Jersey City died on June 27. A graduate of New York Eclectic Medical School, class of 1927, Dr. Flichtenfeld practiced anesthesiology and was affiliated with the Jersey City Medical Center. He was a recipient this past May of the Medical Society of New Jersey's Golden Merit Award given for 50 years of practice. Dr. Flichtenfeld was 74 years of age at the time of his death.

### **Dr. Carye-Belle Henle**

Carye-Belle Henle, M.D., the first woman radiologist in New Jersey, died on July 14 at her home in Kinnelon. She had been active for over 35 years in the long-range radium research project of the New Jersey Department of Health. A graduate of the Columbia University College of Physicians and Surgeons in



1925 Dr. Henle pursued a career in radiology, becoming board certified in that specialty, and a Fellow of the American College of Radiology. She had been associated with Martland and St. Michael's Hospitals in Newark and also had been clinical associate professor emeritus in the department of radiology at the New Jersey Medical School. She had served two terms as secretary of the American Medical Women's Association, whose New Jersey affiliate named her Woman of the Year in 1961. Dr. Henle was a member of the New Jersey Radiology Society and had been its president in 1956. She was a laureate of MSNJ's Golden Merit Award in 1975.

#### **Dr. Theodore Hirsch**

One of Essex County's senior members, Theodore Hirsch, M.D., died last May. Born at the turn of the century in Edenkoben, Germany, Dr. Hirsch was graduated from the University of Heidelberg School of Medicine in 1926. He emigrated to the United States in the 1930's and established a practice in obstetrics in Newark in 1939. Dr. Hirsch was associated with Newark Beth Israel and Irvington General Hospitals. He was a Fellow of the American College of Obstetrics and Gynecology and of the American Academy of Obstetrics and Gynecology, and was a member of the Academy of Medicine of New Jersey. He retired from private practice in 1962 and worked full time in the outpatient clinic of the Veterans Administration facility in Newark.

#### **Dr. Franz Husserl**

On July 14, Franz W. Husserl, M.D., a member of our Monmouth County component, died in Monmouth Medical Center, Long Branch. He had maintained a private practice in psychiatry in Ocean Township for many years and was affiliated with the Monmouth Medical Center, where he was director of child psychiatry, and with Hahnemann Medical College in Philadelphia, where he was associate clinical professor of psychiatry. Born in Newark in 1914, Dr. Husserl was graduated from Downstate Medical Center, class of 1947, and pursued his

graduate training at Columbia-Presbyterian Medical Center.

#### **Dr. Gerald W. Husted**

On July 10, Gerald W. Husted, M.D., a member of our Camden County component, died of a heart ailment. Born in 1910 and graduated from Temple University School of Medicine, class of 1936, Dr. Husted practiced general medicine in Camden County for many years. He had been on the staff at Cooper Medical Center in Camden. Dr. Husted retired from active practice in 1974 and moved to Ocean City where he was residing at the time of his death.

#### **Dr. Rafael A. Jacobo**

Word has just been received of the death on April 26 of Rafael A. Jacobo, M.D., a member of the Passaic County Medical Society. Born in 1908 in the Dominican Republic, Dr. Jacobo was graduated from the medical school of Santo Domingo University there in 1934 and emigrated to New Jersey to practice general medicine with special interest in gastroenterology. He had been on the staff at St. Joseph's Hospital in Paterson in the department of medicine and was a Fellow of the American College of Gastroenterology.

#### **Dr. Philip Klarich**

Philip Klarich, M.D., a member of our Camden County component, died on July 14 at Underwood Memorial Hospital in Woodbury. Dr. Klarich earned his medical degree from the University of Vienna, class of 1938, and pursued graduate work in obstetrics and gynecology at the Graduate Hospital of the University of Pennsylvania. He was a diplomate of the American Board of Obstetrics and Gynecology and a Fellow of the American College of Obstetrics and Gynecology. He had been on the staff at Cooper Medical Center in Camden and Salem County Memorial Hospital in Salem, and was on the faculty at the University of Pennsylvania Graduate School of Medicine and at Hahnemann Medical College in Philadelphia. Dr. Klarich was 65 years old at the time of his death.

### **Dr. Henry Metz**

We have just learned of the death on June 12 of Henry Metz, M.D., a member of our Bergen County component. Born in 1910 and graduated from St. Louis University School of Medicine in 1935, Dr. Metz pursued a career in urology and was board certified in that specialty. He was director of urology at Hackensack Hospital and a member of the attending staff at Bergen Pines Hospital in Paramus. During World War II, Dr. Metz served five years with the department of medicine in the Army of the United States.

### **Dr. Theodore Morici**

Word has been received of the death on May 6 of a former member of the Passaic County Medical Society, Theodore Morici, M.D. A graduate of McGill University in Montreal, class of 1926, Dr. Morici practiced general surgery in Passaic County and had been on the staff of that department at the Beth Israel Hospital there. He was a diplomate of the American Board of Abdominal Surgery and a Fellow of the American Society of Abdominal Surgeons. Dr. Morici was 81 years old at the time of his death.

### **Dr. Philip J. Santora**

Philip J. Santora, M.D., former assistant medical director at Martland Medical Center, Newark, died in Presbyterian Hospital on June 24. Born in 1901 and graduated from the Boston University School of Medicine in 1927, Dr. Santora took graduate work in radiology, both diagnostic and therapeutic, at Harvard Medical School, Columbia University's College of Physicians and Surgeons, New York University, and the University of Pennsylvania. He was a diplomate of the American Board of Radiology and a Fellow of the American College of Radiology. Other memberships included the American College of Hospital Administrators, the Roentgen Society of North America

the New Jersey Radiology Society, and the Academy of Medicine of New Jersey. Dr. Santora also was a Fellow of the American Geriatric Society. He retired from active practice in 1963 and moved to Brielle. He served as a consultant in radiology for the Point Pleasant Hospital and was police surgeon for the town of Sea Girt.

### **Dr. Ernest Stark**

One of Monmouth County's senior members, Ernest Stark, M.D., died on June 28 in Hallandale, Florida, after a three months' illness. A native of Hungary, Dr. Stark received his medical degree in 1927 from the Royal University of Modena, Italy, and emigrated to the United States in 1933 to pursue graduate work at Margaret Hague Medical Center in Jersey City and the New York Post Graduate Medical School. He practiced general medicine in New York until moving to Red Bank in 1954 and later to Little Silver and Bradley Beach. Dr. Stark retired in 1974 to make his home in Florida. He had been affiliated with Monmouth Medical Center in Long Branch and the Riverview Hospital in Red Bank, and was a member of the American Academy of Family Practice. Dr. Stark was a this year's recipient of MSNJ's Golden Merit Award. He was 78 years old at the time of his death.

### **Dr. Bruno W. Zaneski**

Word has just been received of the sudden death on June 12 of Bruno W. Zaneski, M.D., a member of our Sussex County component. Born in 1920 and graduated from New York Medical College, class of 1945, Dr. Zaneski took a residency in pathology at Doctors' Hospital, New York and in obstetrics and gynecology at Bellevue Hospital there. He practiced the latter specialty in New York City and Westbury, Long Island before coming to Newton in 1965. Dr. Zaneski was board certified in obstetrics and gynecology and on the attending staff in that department at Newton Memorial Hospital.

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\* **WRITE FOR REPRINT:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahoglu, M.D.: Hormones for Improved Sexuality in the Male and Female. *Climacteric Drug Therapy*, Sept. 1976.

Is there a true aphrodisiac? How effective are androgens in the management of the male climacteric and male impotence? Article discusses the psychophysiological and hormonal changes in the elderly male and female and therapeutic considerations. The effectiveness of methyltestosterone in the management of male impotence was confirmed by a cross-over, double-blind study using a placebo and Android-25

(methyltestosterone 25 mg.), on 20 males, 50 years of age or older who complained of secondary impotence. Patients received a series of placebo then Android-25, or Android-25 then placebo as follows: 1 tablet/30 days; 2 tablets/30 days; 3 tablets/30 days. Sexual response was evaluated: 0 = no change; - = 25% improvement; ++ = 50% improvement; +++ = 75% improvement. Placebo effectiveness was - or ++ in 12.7% of trials. Android-25 elicited a +, ++ or +++ response in 47.2% of trials. There was often a dose related response not observed with the placebo. This effect was not observed in younger patients (age 28-45 years).

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avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

**REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. In the male: Eunuchoidism and eunuchism, 10 to 40 mg. Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpubertal cryptorchidism, 30 mg. **REFERENCE:** Robert B. Greenblatt, M.D., and D. H. Perez, M.D.: The Menopausal Syndrome, "Problems of Libido in the Elderly," pp. 95-101. Medcom Press, N.Y., 1974. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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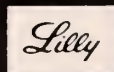
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# EDITORIALS

## Big Truth vs Big Lie

Hitler was a master at the use of the "big lie," a fact over which Germany and the civilized world will suffer until the end of time. It is certainly clear that the "big lie" now is being used and directed at physicians and the present system of medical practice in the United States by some politicians and some political journalists.

The purposes of the dictator's use of this propaganda technique were clear—to gain political power and to change the system. The purposes of the politicians and the politically oriented journalists are the same.

Among the elements of the big medical lie in the speeches and press one can find the following:

1. American Medicine, as it is presently provided, is second rate.
2. The high cost of health care in the United States is the fault of the doctor.
3. The way to contain costs in the American health care system is through government regulation.
4. Fiscal controls on health care costs are possible with no sacrifice of quality.
5. The American public is anxious for and will benefit from a national health service after the fashion of the British system.
6. The way to control physicians is to put them on salary paid for by the government.

The politicians and writers who use this technique know that the truth easily can be determined about each of these points. It is very important that the recipients of such distorted propaganda also be informed of the truth, so they can make a judgment in advance rather than regret the bitter pill which will be pushed

down their uncomplaining throats, if they apathetically and ignorantly allow it to occur.

It is essential for New Jersey physicians and American Medicine to combat "the big lie" with "the big truth." The facts are:

1. American Medicine is the best in the world if one takes into account *all* the statistics of morbidity and mortality, the safety and efficacy of drug research, the development and application of new therapeutic methodology through careful research, accessibility to the health care system, the training of physicians and other professionals and all the other elements of the system.
2. The high cost of health care in the United States is due to increased hospital bed utilization and intrinsic hospital costs due to the application of expensive new methods and equipment developed through scientific advancement. Other factors of significance are inflation and the considerable financial burden of government regulations themselves.
3. The track record of government regulation in all other fields—space research, the search for new sources of energy, the postal system, and on and on—with blunders, cost over-runs, and pure waste is so bad that one cannot believe that total government control of the health care system will be anything but a financial disaster.
4. It is a virtual impossibility for government to place stifling cost controls on the health care system without some deterioration in the quality of health care. The fact is that introduction of such a system results in so-called health "priorities" which inevitably exclude many major benefits including health education and disease detection and which result in inordinate waiting periods for hospital admission and consultations with specialists, and the like. Second rate diagnosis and treatment must result.
5. The nature and temperament of the American public is such that it will not tolerate a system like the one which exists in the United Kingdom. The dissatisfaction with the delays,



the layer upon layer of regulations, and the restrictions of self-determination would produce an explosive reaction in our citizens rather than the stoical tolerance exhibited by the British.

6. American physicians are a product of the free American spirit which encourages individual initiative and productivity. A total system of salaried positions would be intolerable to the temperaments of practitioners in this country—as it would be for the lawyers and other professionals who might encourage such a system.

The time has come in New Jersey—and in the United States—to utilize the *Big Truth* and to inform the public and especially our patients of the real facts. A.K.

## Bye, Bye Phenformin

After several years of debate and controversy, the FDA finally has acted to remove phenformin from the list of available antidiabetic oral agents for routine use. Lest there be any confusion, it should be understood that this decision was not related to the University Group Diabetes Program study (UGDP), (see *JMSNJ* 72:970-971, 1975) but to reports of fatal lactic acidosis associated with phenformin therapy in patients with diabetes. The FDA director's decision was based on his conclusion that the continued use of phenformin constituted a hazard which was not justified by the potential benefits of the drug. The drug's use thus constituted an "imminent danger" to its user, according to the government.

Was this decision justified? It would take volumes to debate that question. Your editor prescribed phenformin daily for hundreds of patients over more than two decades. Careful selection of patients, appropriate dosage schedules, regular monitoring of symptoms and signs, and prompt reduction in dosage or cessation of the drug with mild or moderate side effects made it possible to use this medication for the benefit of the patients without any cases of lactic acidosis.

The fact is that a number of university-level diabetologists were worried about the phenformin-lactic acidosis relationship. Although cause and effect were not unequivocally verified, it seemed wise for them and the American Diabetes Association representatives to accept the FDA decision. In any case, the arguments for continuing the use of this biguanide were rather weak.

Will we miss phenformin? The major use of this medication was adjuvant therapy for the patient who failed to respond to diet and sulfonylurea drugs alone. The synergistic effect of the sulfonylurea-biguanide combination worked very well in many such patients. It now appears that the FDA still may permit the limited use of phenformin for those patients who are not controlled by diet alone or diet plus sulfonylurea drug and for some reason cannot take insulin.

For most physicians, it's "bye, bye, phenformin." If a patient fits into the category described above—and such a patient would be rare indeed—one still might press for the use of phenformin.

A.K.

### Cover Photo

Our cover is a reproduction of the blue ribbon winner for sculpture in the Woman's Auxiliary Art show held in conjunction with the 211th Annual Meeting of the Medical Society of New Jersey. The artist is Clare Poliakoff, wife of Dr. Ben Poliakoff, a family practitioner in Maple Shade. The subject of the prize-winning sculpture is their son, a Rhodes scholar at Oxford. The Poliakoffs, both art collectors, have a second son who is a third-year medical student.



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**Adverse Reactions:** On rare occasions oral administration of the drug has been associated in time with the occurrence of hypotension, tachycardia, nausea, vomiting, dizziness, abdominal distress, and severe rash. If rash appears the drug should be discontinued.

Although available evidence suggests a temporal association of these reactions with isoxsuprine, a causal relationship can be neither confirmed nor refuted.

Administration of single dose of 10 mg. intramuscularly may result in hypotension and tachycardia. These symptoms are more pronounced in higher doses. For these reasons single intramuscular doses exceeding 10 mg. are not recommended. Repeated administration of 5 to 10 mg. intramuscularly at suitable intervals may be employed.

**Supplied:** Tablets, 10 mg., bottles of 100, 1000, 5000 and Unit Dose, Tablets, 20 mg., bottles of 100, 500, 1000, 5000 and Unit Dose; Injection, 10 mg. per 2 ml. ampul, box of six 2 ml. ampuls.

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# ORIGINAL ARTICLES

*Gynecomastia may be unilateral or bilateral. Bilateral gynecomastia often is related to medication, but also may be the result of fibrocystic disease. Unilateral gynecomastia is caused by the same etiologic agents. In these cases, however, the clinical suspicion of carcinoma is higher particularly in the presence of a palpable mass. Four major x-ray patterns were noted. These are the hemispherical pattern, spherical pattern, cone pattern, and diffuse pattern. Degrees of homogeneity of these patterns are related to the relative amounts of ductal and fibrous proliferation. Recognition of these patterns may be helpful in the diagnosis of male breast carcinoma. The possible relationship between histopathologic gynecomastia and carcinoma also adds to the usefulness of mammography in the diagnostic evaluation of gynecomastia.*

## Mammographic Diagnosis of Gynecomastia

**Daniel S. Cukier, M.D., Hackensack\***

Clinical gynecomastia, the excessive development of the male breast, may be unilateral or bilateral. When bilateral, the diagnosis can be abetted by a history of exposure to certain medications (see Table 1). It also may result from liver disease, testicular tumors or atrophy, advanced malnutrition, abnormal weight gain (pseudogynecomastia), or as a normal accompaniment of puberty. Less frequently, it may occur as the result of fibrocystic mastopathy. Unilateral gynecomastia also can result from the same etiologic factors, but one must rule out a tumor if there is a palpable mass.

This paper will present the various mammographic patterns of gynecomastia other than neoplasm. The clinical impression of gynecomastia can be confirmed by mammography, which should be helpful in the differentiation from cancer.

### Histopathology

In their description of 218 cases of gynecomastia Sirtori and Veronisi<sup>1</sup> stated that it was impossible to distinguish histopathologically between the hormonal and non-hormonal types of gynecomastia. Both have an increase in the fibrous supporting and periductal tissues, and a proliferation of the glandular elements. Often, atrophy and proliferation of the ductal tissue coexist. The few ducts present were described as dilated, elongated, and twisted, while lobular alveolar proliferation was almost non-existent. Occasionally, proliferation of ducts occurred so as to form sacculations of the terminal ducts

simulating cysts. These, together with increased fibrous elements, created a pattern compatible with female fibrocystic disease. On occasion, glandular elements proliferated to such an extent as to form papillomas.

Table 1  
Drugs That May Cause Gynecomastia\*

Adrenacortical hormones  
Adragens  
Busulfan (Myleran®)  
Cardiac glycosides  
Chlortetracycline (Aureomycin®)  
Contraceptives, Orol (Ovasistan®)  
Diethylstilbestrol  
Digitalis  
Digitoxin  
Estragens  
Ethionomide  
Griseofulvin (Grifulvin®)  
Haloperidol (Haldol®)  
HCG (human chorionic gonadotropin)  
Herain  
Hormones  
Isaniazid  
Methyldopa  
Methyltestosterone  
Phenaglycadal (Ultran®)  
Phenelzine (Nardil®)  
Phenothiazines  
Reserpine  
Spironolactone (Aldactone®)  
Steroids  
Stilbestrol  
Vincristine (Oncavin®)  
Vitamin D<sub>2</sub>

\*Martin E, Alexander S: *Hazards of Medication*, Philadelphia, J. B. Lippincott, 1971.

\*Dr. Cukier is Clinical Assistant Professor of Radiology, CMDNJ-New Jersey Medical School, Newark.



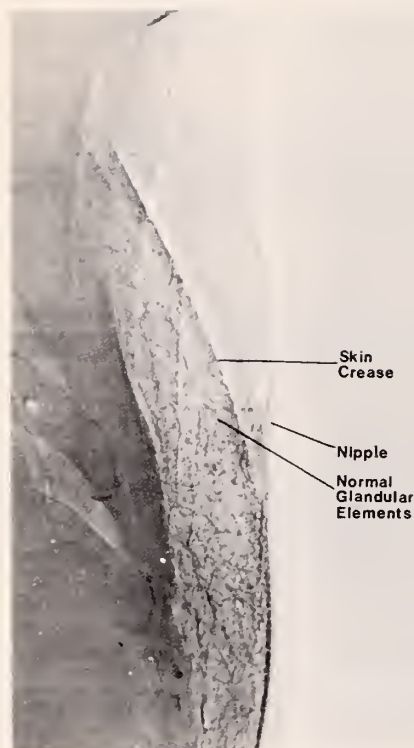


Figure 1—Normal male breast (small): Normal mammogram of a thin male. Note sparse ductal and fibrous elements.

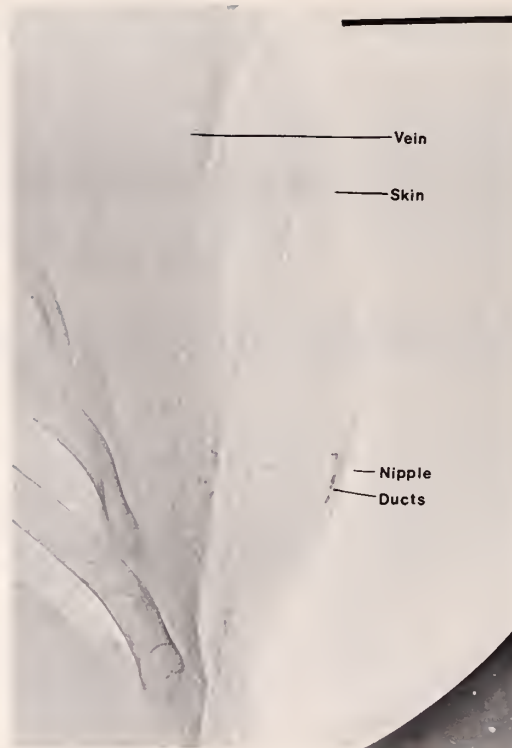


Figure 2—Normal male breast (average size): Normal mammogram of a patient of average weight. There is moderately more adipose tissue than that seen in a thin patient but the glandular and fibrous elements are sparse

## Radiographic Findings

Twenty-one patients with clinical gynecomastia underwent xeromammography following a history and a clinical examination of the breasts (see Table 2). Our review of clinical gynecomastia revealed four major distinctive radiographic patterns:

1. Hemispherical density with posterior tapering.
2. Spherical density "ball-like."
3. Cone density.
4. Diffuse density.

These four patterns were further subdivided into a homogeneous or non-homogeneous category, depending upon the amount of fibrous tissue accompanying the abnormally developed glandular elements.

The mammogram of young, average-weight males reveals sparse glandular and fibrous elements and a paucity of adipose tissue (Figure

2). With weight gain and in middle-aged and older individuals, the mammogram reveals increased deposition of adipose tissue, so that the glandular and fibrous elements occupy proportionately less of the breast (Figures 2 and 4).

The absolute degree of stimulation of the glandular and fibrous elements appears to account for the four basic x-ray configurations observed, i.e., the spherical pattern may represent an advanced stage of the hemispherical, and a cone pattern (Figure 5) the precursor of the hemispherical pattern (Figure 3). The rare diffuse pattern (Figure 7), seen in one case, appears to be the result of fibrous predominance and minimal glandular elements.

The relative degree of glandular and fibrous element stimulation accounts for the degree of homogeneity present. A predominantly

Table 2  
Clinical and Mammographic Summary

Case	Age	Etiology	Clinical Findings	Radiographic Appearance
#1	15	Pubertal	Unilateral (L) Tender subareolar swelling	Increased glandular and fibrous elements No adipose tissue Uniformly dense Hemispherical pattern
#2	15	Pubertal	Bilateral Tender subareolar swelling	Increased glandular and fibrous elements No adipose tissue Uniformly dense Hemispherical pattern
#3	34	Weight Gain	Bilateral Nontender diffuse enlargement	Normal glandular elements Increased adipose tissue
#4	65	Weight Gain	Bilateral Nontender diffuse enlargement	Normal glandular elements Increased adipose tissue
#5	69	Estragen	Bilateral	Dilated glandular elements Non-homogeneous density Cone pattern
#6	63	Estrogen	Bilateral Tender swelling	Increased glandular and fibrous elements Uniformly dense Cone pattern
#7	80	Estragen	Bilateral L>R Tender swelling	Increased glandular and fibrous elements Uniformly dense Cone pattern
#8	78	Estragen	Bilateral Tender, firm swelling ? mass	Increased glandular and fibrous elements Uniformly dense Spherical pattern
#9	64	Estrogen	Bilateral Tender swelling	Dilated glandular elements; some fibrosis Non-homogeneous density Hemispherical pattern
#10	65	Estrogen	Bilateral Tender swelling	Dilated glandular elements Non-homogeneous density Cone pattern
#11	70	Aldomet® (methyldopa)	Unilateral (L) Non-tender swelling	Dilated glandular elements Non-homogeneous density Cone pattern
#12	69	Serpasil® (Reserpine)	Unilateral (L) Non-tender swelling	Dilated glandular elements; some fibrosis Non-homogeneous density Diffuse pattern
#13	41	Aldactone® (Spironolactone)	Bilateral Tender Swelling	Increased glandular and fibrous elements Homogeneous density Cone pattern
#14	44	Aldactone®	Unilateral (L) Non-tender swelling	Dilated glandular elements; some fibrosis Non-homogeneous density Spherical pattern
#15	61	Diuril® (Chlorothiazide)	Bilateral L>R Non-tender swelling	Dilated glandular elements; some fibrosis Non-homogeneous density Spherical pattern

#16	29	Prednisone	Unilateral (R) Non-tender swelling ? mass	Dilated glandular elements; some fibrosis Non-homogeneous density Spherical pattern
#17	64	Digoxin	Unilateral (L) Non-tender swelling ? mass	Dilated glandular elements Non-homogeneous density Cane pattern
#18	52	Aldactone® and Fibrocystic	Bilateral Tender swelling	Left: Dilated glandular elements; same fibrosis Non-homogeneous density Diffuse Pattern Right: Coarse calcifications
#19	56	Fibrocystic Disease	Unilateral (L) Non-tender swelling Mass	Dilated glandular elements; some fibrosis Non-homogeneous density Spherical pattern
#20	48	Fibrocystic Disease	Unilateral (L) Non-tender swelling Mass	Increased glandular and fibrous elements Homogeneous density Cane pattern
#21	58	Fibrocystic Disease	Non-tender soft mass	Cyst; coarse calcifications

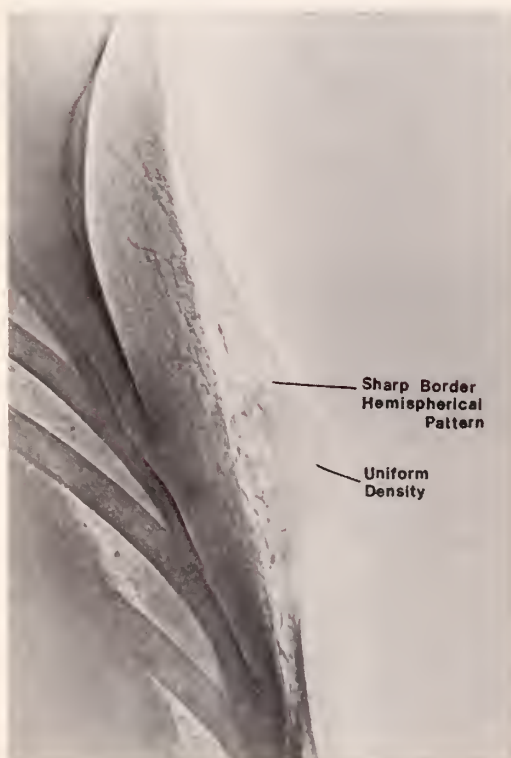


Figure 3 — Pubertal gynecomastia "hemispherical" pattern: Pubertal gynecomastia reveals increased glandular and fibrous elements blending to form a hemispherical pattern with sharp borders anteriorly, superiorly, and inferiorly. Most of the breast is involved in the process with little adipose tissue present.

glandular stimulation will result in a non-homogeneous pattern (Figure 9) whereas equal stimulation of fibrous and glandular elements results in a homogeneous dense pattern (Figures 3 and 6).

### Discussion

Egan<sup>2</sup> briefly described patients with gynecomastia whose x-rays revealed increased deposition of adipose tissue without concomitant glandular proliferation. Usually these were associated with some degree of proliferating breast tissue. On occasion, the enlargement of the glandular tissue presented as a round mass just beneath the nipple and stimulated the fibrous-type of fibrocystic disease. This cyst-like circumscribed mass measured from several millimeters up to two centimeters. Lastly, Egan described patients with gynecomastia who presented with generalized diffuse glandular prominence.

Wolfe<sup>3</sup> concluded from his cases that the breasts affected with gynecomastia radiographically were not unlike those seen in the young girls with mammary dysplasia or those with ovarian agenesis receiving treatment for their condition. He observed that the space from the subareolar

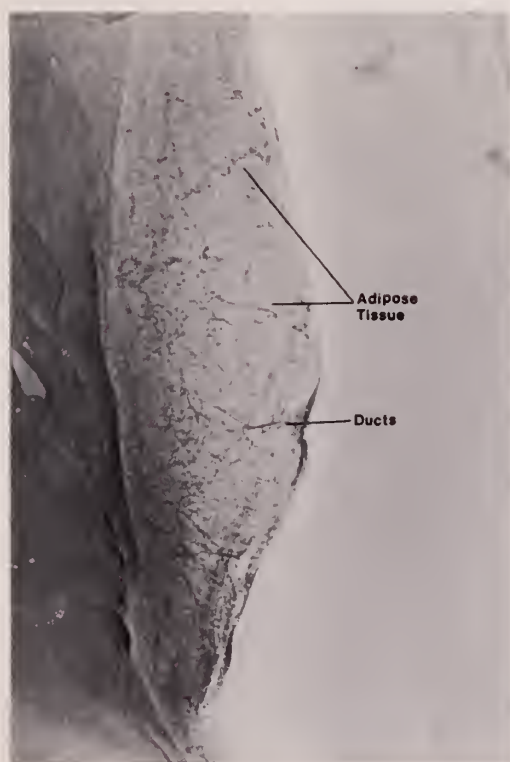


area to the depths contained widened, duct-like structures appearing straight rather than tortuous. He noted increased densities of a glandular nature, similar to minor adenosis seen in females, but he never observed changes suggesting cysts, fibroadenomas or "benign" calcifications as seen in the female breast.

Our findings indicate that no single radiographic pattern is distinctive of a particular etiology, i.e., hormonally and non-hormonally caused gynecomastia may have a similar appearance. Conversely, one etiologic factor can stimulate different patterns. When bilateral, dissimilar patterns are frequently but not always present. We cannot be certain that the underlying (prestimulation) normal pattern predisposes the breast to a specific pattern after drug stimulation. Further investigation will be required to correlate patterns of gynecomastia with the duration of drug use.

When fibrocystic disease occurs, it presents with less significant breast enlargement and more palpable abnormality than drug-induced gynecomastia. Our findings, contrary to those of other observers, indicate that fibrocystic disease in the male breast can present with calcifications similar to those seen in women (Figure 8).

The radiographic appearance of gynecomastia confirms the histopathologic findings of Sirtori and Veronisi. (Figure 11). Specifically, there is no visible difference between the hormonally and non-hormonally induced gynecomastia. The degree of fibrosis and its spatial approximation to the glandular elements, as observed microscopically, correlated with the observation of "homogeneous" and "non-homogeneous" radiographic patterns. In addition, the dilated, elongated ducts described histopathologically are clearly identified, especially in the mammo-



*Figure 4—Adipose (pseudo) gynecomastia:* Mammogram of patient with excessive weight gain reveals increased deposition of adipose tissue only. Since the glandular and fibrous elements appear normal, this can be considered pseudogynecomastia.



*Figure 5—Estrogen gynecomastia "cone" pattern:* Gynecomastia resulting from estrogenic medication is present here with a cone pattern, which characteristically tapers posteriorly. The relatively uniform density results from the blending of glandular and fibrous elements.

grams where minimal fibrosis is present. A cyst observed radiographically (Figure 10) was assumed to represent a case of saccular dilation of the terminal duct.

By contrast, many radiographically documented cases of cancer present with a picture similar to scirrhous carcinoma of the female breast (Figure 12). Kalisher<sup>8</sup> described carcinomas as dense retroareolar masses with irregular margins and early skin changes, often associated with enlarged axillary lymph nodes. His two cases were subareolar and above the mid-plane of the nipple. According to Eagan<sup>2</sup>, by the time the lesion reaches radiographic attention, it is far advanced so that the entire breast is infiltrated. This author has seen two such patients in whom the diagnosis was clinically evident and skin ulceration was present although the radiograph was non-specific.

#### Comment

As stated by this author in a previous paper<sup>4</sup>,

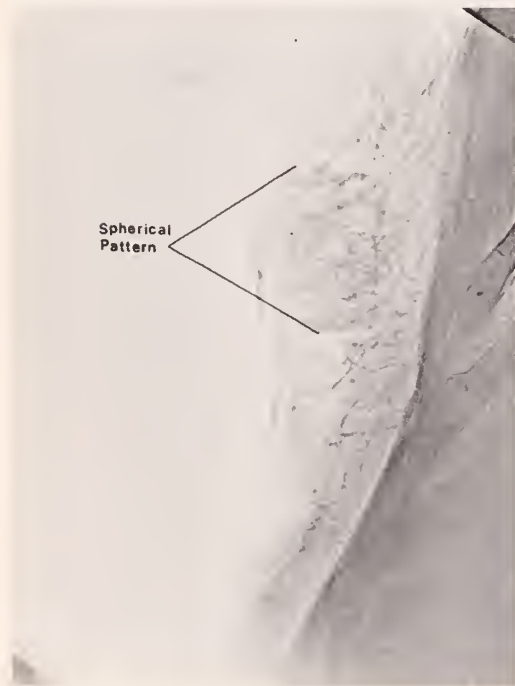


Figure 6—Estrogen gynecomastia "spherical" pattern: Estrogenic medication resulting in gynecomastia with a spherical pattern. Often the "ball-like" configuration presents clinically as a mass. Note the uniform density with posterior tapering.



Figure 7—Reserpine gynecomastia "diffuse" pattern: The diffuse pattern of Serpasil-induced gynecomastia is evident by a lack of a distinct configuration. Because the pattern is disorganized, there is never a palpable mass.

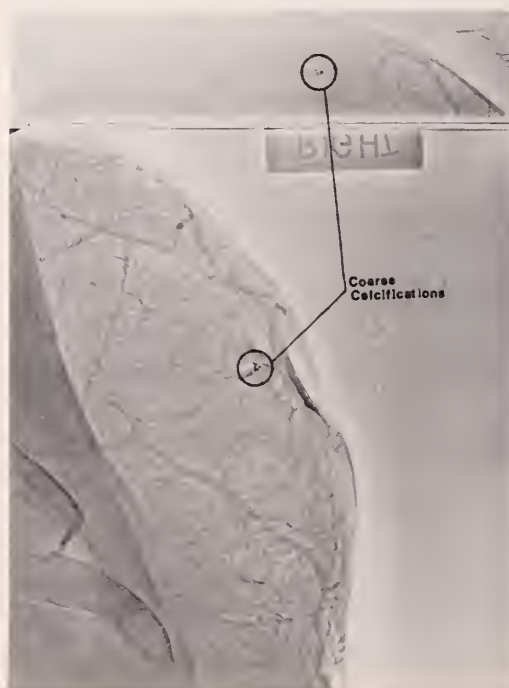


Figure 8—Aldactone gynecomastia and fibrocystic disease: Coarse calcifications are clustered in the subareolar area. (These are identical to those seen in females with fibrocystic disease). Aldactone gynecomastia with a diffuse pattern was present also in the opposite breast.

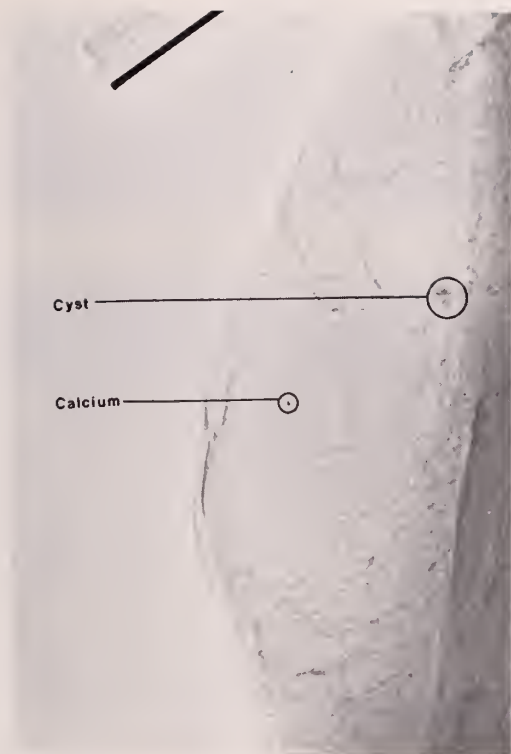


Figure 9—Fibrocystic Gynecomastia "spherical pattern": Fibrocystic disease presenting as unilateral gynecomastia with a spherical pattern of non-uniform density. This is a result of predominately ductal dilatation.

careful physical examination and precise correlation of the physical and xeromammographic findings lead to the best understanding of the male breast abnormality just as it does in the female. The mammographic patterns of benign gynecomastia easily are recognizable once the four basic patterns are identified. Conversely, patterns other than those should be considered as suspicious of neoplasm.

Little attention has been paid to mammography of the male breast because of the justified interest in the more prevalent female breast cancer. However, some observers have commented on the possibility of gynecomastia as a precursor of carcinoma.

Holleb<sup>3</sup>, in his review of 198 cases of male breast cancer seen at Memorial Hospital in New York found a single thirty-five year old patient in whom cancer was associated with histopathologic gynecomastia.

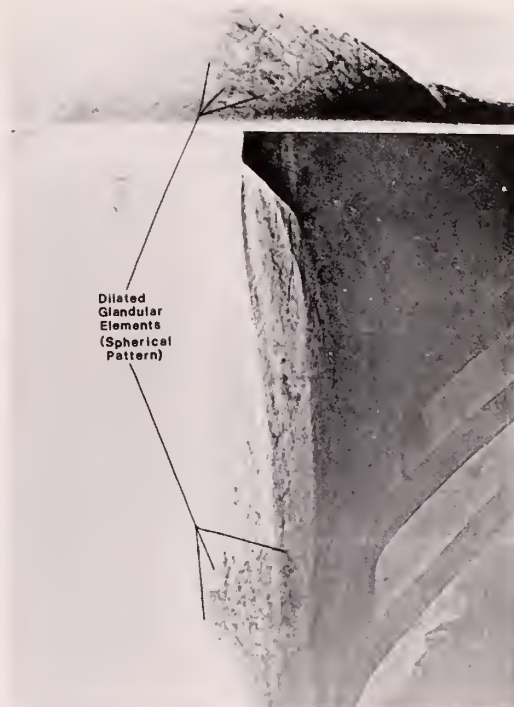


Figure 10-A

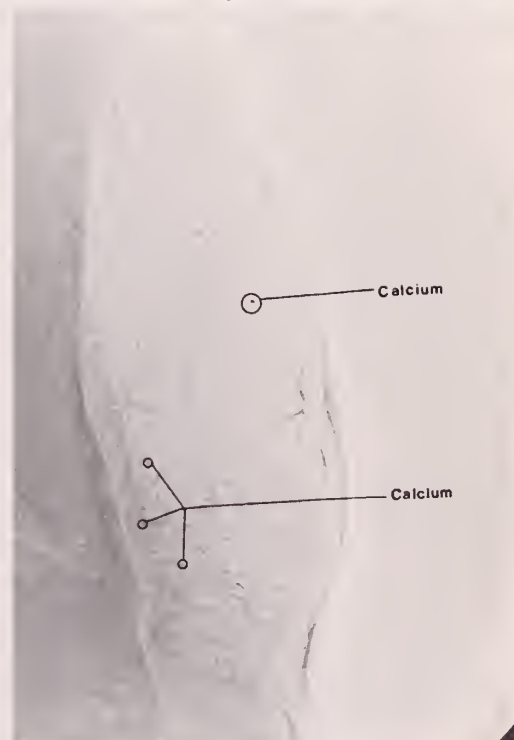


Figure 10-B

Figure 10—Fibrocystic disease and calcifications: Over-weight patient with fibrocystic disease. A palpable mass corresponded to the sharply defined nodule observed on mammogram, characteristic of a cyst (Fig. 10A). Note the coarse calcifications in both breasts.





Figure 11—Histopathology of gynecomastia: Ducts lined by epithelium displaying low papillary projections. The ducts are set within a proliferating fibrous stroma without glands.

Liechty, *et al.*<sup>6</sup> report forty men with breast cancer, seven of whom (17.5%) were associated with gynecomastia. They postulated that carcinomas can be expected to develop since gynecomastia is characterized by stromal and ductal proliferation in which epithelial hyperplasia may be brisk so as to form papillomata. Concluding that the association between gynecomastia and carcinoma warranted careful study, they performed excisional biopsy of clinical gynecomastia in the older age group.

Norris and Taylor<sup>7</sup> reviewed 113 men with breast cancers at the Armed Forces Institute of Pathology and discovered that five percent of them had bilateral clinical gynecomastia. Their impression was that male breasts with carcinoma often revealed an unexpected quantity of stroma and associated benign ducts, although there was no histologic proof of the transformation of gynecomastia to carcinoma.

All observers agree that the early detection of carcinoma affords the best chance of cure. Therefore, we contend that most cases of



Figure 12—Carcinoma (Courtesy of J. Wolfe, M.D.) Irregular dense mass associated with localized skin thickening.

gynecomastia regardless of etiology should undergo mammography, since the identification of benign and malignant conditions may be possible.

## References

1. Sirtori C, Veronisi U: Gynecomastia: A review of 218 cases. *Cancer* 10:645-654, 1957.
2. Egan R: *Mammography and Breast Diseases*. Baltimore, Williams and Wilkins Co., 1970, pp. 226-227.
3. Wolfe J: *Xeroradiography of the Breast*. Springfield, Illinois, Charles C. Thomas, 1972, pp. 162-163.
4. Cukier D: The assets and liabilities of mammography. *Surg Gynecol Obstet* 141:896-898, 1975.
5. Holleb A: *Cancer of the Male Breast: Breast Cancer Early and Late*. Chicago, Year Book Medical Publishers, 1970, pp. 245-260.
6. Liechty R, Davis J, Gleysteen J: Cancer of the male breast. *Cancer* 20:1617-1624, 1967.
7. Norris H, Taylor H: Carcinoma of the male breast. *Cancer* 23: 1428-1453, 1969.
8. Kalisher L, Peyster R: Xerographic manifestations of male breast disease. *Rad Ther Nucl Med* 123: 656-661, 1975.

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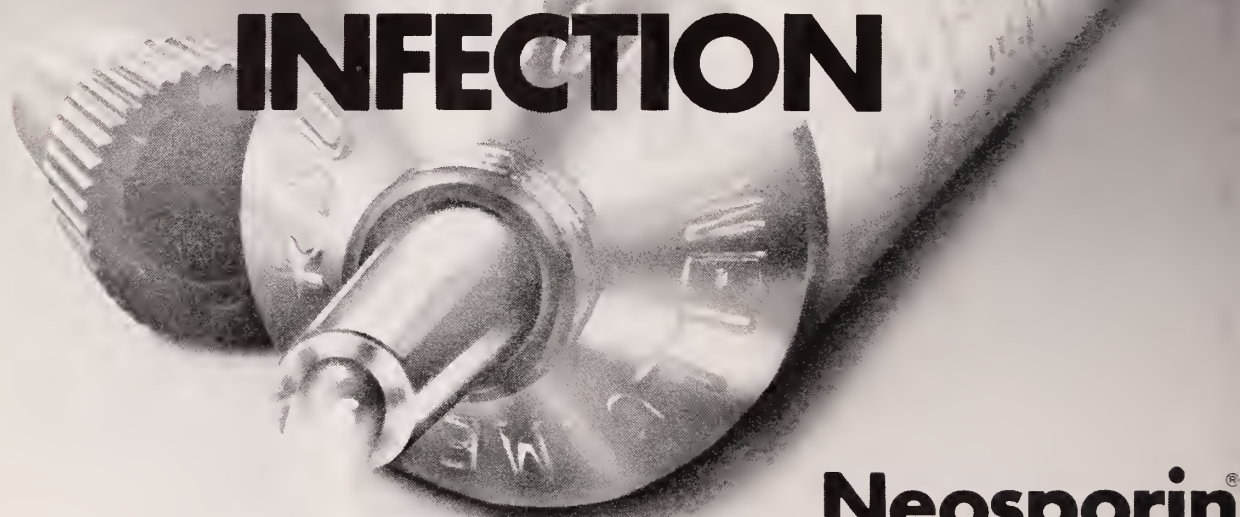


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*Charts of eighteen practicing pediatricians were audited for management of acute illness and validated by direct observation. Criteria, developed as indices of good care, included use of throat cultures in pharyngitis, follow-up of acute otitis media, and avoidance of the use of antibiotics in nonbacterial disease. Of patients with pharyngitis 62 percent were cultured, 35 percent with otitis were seen in follow-up, and 33 percent of patients with nonbacterial illness received antibiotics. Physicians who performed well in one category tended to perform well in all three, though statistical significance was not obtained.*

## Management of Infectious Disease in Pediatric Practice

**Samuel Gidding, Roger Wint, and  
Richard H. Rapkin, M.D., Green Brook**

A survey was done in 1971 to assess the use of throat cultures in pediatric practice<sup>1</sup>. The results revealed that physicians who frequently did office throat cultures appropriately managed infectious diseases more often than physicians who did not obtain cultures. It could not answer the question of whether throat culturing was the cause or result of good office practice. Because the data were obtained by questionnaire response only, neither the veracity of the responses nor the similarity of the respondent and nonrespondent pools could be assessed.

To compensate for these flaws and to update the previous study, a method for directly surveying pediatric practice habits was developed. That there was an association between regular throat culture use and appropriate management of infectious diseases was the working hypothesis.

### Methods

Criteria were developed as indices of good infectious disease practice:

1. Obtaining throat cultures on all patients with pharyngitis (sore throat, tonsillitis, or fever)<sup>2</sup>
2. Follow-up for all patients with acute otitis media<sup>3</sup>
3. Avoiding use of certain medications in acute nonspecific gastroenteritis (atropine, opium, kaolin, pectin, or antibiotics)<sup>4</sup>
4. Avoiding antibiotic therapy in patients with nonbacterial acute illness<sup>5</sup>.

Twenty pediatricians' offices were visited. After a brief interview of the physician, charts were selected at random from his files, and the most recent acute illnesses were reviewed. The illnesses were grouped as pharyngitis, otitis media, gastroenteritis, other localized disease (e.g., upper respiratory infection, conjunctivitis), or nonlocalized disease (e.g., acute fever of unknown origin).

The illnesses were defined as bacterial if any of the following criteria were met: throat culture positive for beta hemolytic streptococcus, otitis media diagnosed, other localized disease diagnosed (e.g., impetigo, abscess, pneumonia, urinary tract infection), stool culture positive gastroenteritis (e.g., salmonella), or if the physician explicitly stated that the disease entity probably had a bacterial etiology. Other diseases such as upper respiratory infections or acute nonlocalized febrile disease were not considered bacterial unless supported by objective evidence (e.g., positive culture of nose or throat for beta strep) or unless the physician explicitly so stated.

The physician was then followed in his daily

\*From the Department of Pediatrics, Raritan Valley Hospital, Green Brook, CMDNJ, Rutgers Medical School, where Dr. Rapkin is Associate Professor of Pediatrics. Mr. Gidding and Mr. Wint carried out this study during summer fellowships at Rutgers Medical School. Currently Mr. Gidding is a fourth year medical student at Rutgers and Mr. Wint is at Einstein College of Medicine in the same capacity.

Table I  
*Acute Illness in Office Practice*

Physician	Charts reviewed	Patients with pharyngitis	Patients with otitis	Patients with gastroenteritis	Patients with acute localized disease	Patients with acute non-localized disease
1	82	17	23	9	28	5
2	63	15	14	5	24	5
3	63	16	20	6	20	1
4	67	22	15	2	27	1
5	64	26	20	4	14	0
6	66	20	15	7	20	4
7	65	13	19	5	24	4
8	65	25	15	3	20	2
9	65	24	11	4	22	4
10	67	26	14	4	21	2
11	68	30	16	6	16	0
12	61	19	14	5	20	3
13	61	21	14	3	22	1
14	53	12	17	2	19	3
15	60	16	16	6	19	3
16	72	20	14	5	28	5
17	70	16	21	6	25	2
18	70	22	11	7	21	9
Total	1182	360	289	89	390	54
Average	66	20	16	5	22	3

office routine to clarify chart notation and assess, in general, whether the chart was an accurate reflection of the physician's activities. Two physicians' charts were either illegible or incomplete and were dropped from the study. From 53 to 82 charts of the remaining 18 physicians were surveyed. The data obtained form the basis of this report (Table I).

## Results

The charts reviewed numbered 1,182. There were 360 patients with acute pharyngitis, 289 with acute otitis media, 89 with acute non-specific gastroenteritis, 390 with other localized disease, and 54 with acute nonlocalized disease. For each physician, an average of 66 charts (range 53-82) were reviewed; they showed 20 with pharyngitis (12-30), 16 with otitis (11-23), five with gastroenteritis (2-9), 22 with other localized disease (14-28), and three with non-localized disease (0-9).

Patients with pharyngitis had a culture of their throats taken 62 percent of the time with a range of 0-100 percent. Of patients with pharyngitis (irrespective of cause) 66 percent were

treated with antibiotics with a range of 38-100 percent (Table II).

Patients with otitis media were followed up 35 percent of the time (range 0-75 percent). Of patients with gastroenteritis 49 percent received unnecessary medication (range 14-100 percent). Sixty percent of patients with acute illness of all kinds received antibiotics (range 47-76 percent) despite the fact that the percent of patients with illness for which a bacterial etiology was probable (throat culture positive pharyngitis, acute localized disease defined as bacterial by disease type or by physician) was only 41 percent with a range of 20-56 percent. The "unnecessary" use of antibiotics, therefore, was in those patients with nonbacterial illness receiving same. There were 225 patients in this category (average 13 per physician) or 19 percent of all the acute illness patients seen. Since there were 690 patients with probable non-bacterial illness and 225 were treated with antibiotics, the "Misuse score" was 33 percent (range 0-70 percent (Table III).

Correlation of data for individual physicians revealed the following trends, although the

numbers were too small for statistical validation:

1. The percent of patients with pharyngitis who had cultures was inversely related to the percent of patients with pharyngitis treated with antibiotics (Figure 1);
2. The percent of patients with pharyngitis who had cultures was inversely related to the percent of patients with nonbacterial illness receiving antibiotics (Figure 2);
3. The percentage of patients with nonbacterial illness receiving antibiotics was inversely related to the frequency of follow-up of otitis media (Figure 3).

## Discussion

Chart audits for assessment of quality of care have several drawbacks. They may be incomplete; the physician may fail to record what he has done. They may be inaccurate; the physician may record that which he intended to do but has not done. They may be uninterpretable because of illegibility or because of failure to understand the physician's "code." A recent

survey of chart auditing concluded that "... because of the lack of recording, accurate and meaningful evaluation of ambulatory child health care cannot now be accomplished by chart audit<sup>6</sup>."

Although these drawbacks exist, the chart review in our study may have been more reliable because the physician explained his own code, the reliability of charting was determined by observation, and the audit sought limited information—a disease description and treatment, (i.e., classification into syndromes, use of antibiotics and ancillary medication, evidence of follow-up). All that was required was a chart note indicating that the practitioner thought that the disease was possibly bacterial to allow the illness to be listed as such.

It is disappointing that 38 percent of patients with pharyngitis did not have their throats cultured, despite well-known data that indicate that 1) the etiology of pharyngitis cannot be determined accurately on clinical grounds<sup>7</sup>, 2) the prevention of acute rheumatic fever depends, at least in part, on appropriate treatment of streptococcal pharyngitis<sup>8,9</sup>, and 3) overuse of antibiotics has hazards<sup>10</sup>.

Table II  
Criteria of Infectious Disease Core

Physician	Percentage of pharyngitis throats cultured	Percentage of otitis media followed	Percentage of gastroenteritis Rx'd.	Percentage of patients given antibiotics without indication for some	Percentage of patients with pharyngitis treated with antibiotics
1	100	70	33	0	71
2	87	50	40	24	47
3	87	0	16	8	62
4	86	33	50	36	59
5	85	50	25	15	38
6	85	66	14	5	40
7	84	31	100	7	69
8	76	40	33	10	52
9	71	9	25	30	54
10	65	7	100	61	69
11	63	50	83	38	94
12	53	50	60	38	63
13	52	21	33	42	82
14	41	57	50	29	75
15	31	75	16	34	93
16	30	0	100	56	100
17	13	14	50	41	88
18	0	0	57	70	100
Average	62	35	49	33	66



Table III  
Antibiotic Misuse

Physician	Patients with acute illness	Patients with bacterial illness Percentage	Patients with nonbacterial illness Percentage	Patients receiving antibiotics Percentage	Patients with nonbacterial illness receiving antibiotics Percentage
1	82	39 (48)	43 (52)	39 (48)	0 (0)
2	63	28 (46)	33 (54)	36 (59)	8 (10)
3	63	35 (56)	28 (44)	37 (59)	2 (3)
4	67	31 (46)	36 (54)	44 (66)	13 (19)
5	64	31 (48)	33 (52)	36 (56)	5 (8)
6	66	29 (44)	37 (56)	31 (47)	2 (3)
7	65	31 (51)	30 (49)	33 (54)	2 (3)
8	65	31 (48)	34 (52)	34 (52)	3 (5)
9	65	21 (32)	44 (68)	34 (52)	13 (20)
10	67	26 (39)	41 (61)	51 (76)	25 (37)
11	68	26 (38)	42 (62)	42 (62)	16 (24)
12	61	27 (44)	34 (56)	40 (66)	13 (21)
13	61	22 (37)	38 (63)	38 (63)	16 (27)
14	53	15 (35)	28 (65)	23 (53)	8 (19)
15	60	25 (42)	35 (58)	37 (62)	12 (20)
16	72	18 (25)	54 (75)	48 (67)	30 (42)
17	70	27 (39)	43 (61)	45 (64)	18 (26)
18	70	14 (20)	56 (80)	53 (76)	39 (56)
Total	1182	475 (41)	690 (59)	701 (60)	225 (19)

Equally disturbing is the failure to follow up acute otitis media 65 percent of the time. Chronic serous otitis media frequently follows acute otitis and is often responsible for hearing deficits which may be irreversible<sup>11</sup>. It may be argued that follow-up was done but not noted. This is unlikely since every physician noted such visits, and each physician was asked whether such visits were charted. Some patients were invited back for follow-up but broke appointments. If this is so, the failure still may be the physician's for not adequately explaining the need for a return visit.

Although a large proportion of patients with gastroenteritis received unnecessary medication, the information on these therapies may not have been known to the practicing physician.<sup>4 11</sup> In any event, the number of such patients was too small to draw any meaningful conclusions. Most gastroenteritis was treated "over the phone" without chart notation. Therefore, an accurate spectrum of gastroenteritis treatment could not be obtained.

Misuse of antibiotics in 33 percent of the cases

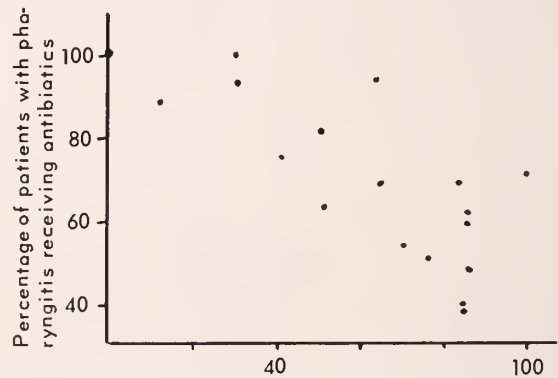


Figure 1 — Percentage of patients with pharyngitis who had throat cultures

where a bacterial etiology was unlikely suggests that there is room for improvement in office use of these drugs in pediatric practice. Pharyngitis was excluded from consideration in this statistic, since not all patients with pharyngitis were cultured, therefore, the appropriateness of therapy could not be determined. That many physicians were able to keep their misuse percentage under ten suggests that improvement in the others is possible.

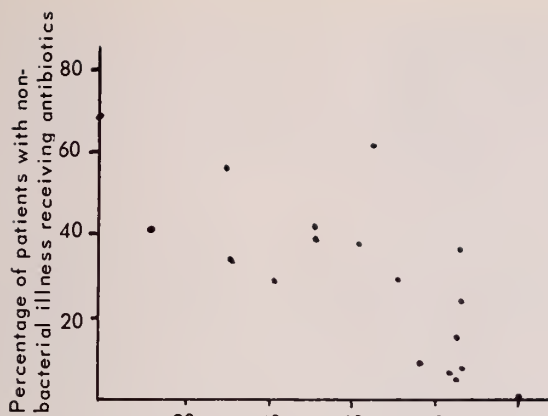


Figure 2 — Percentage of patients with pharyngitis who had throat cultures

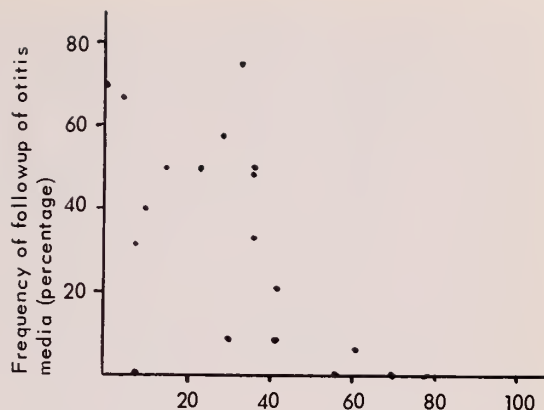


Figure 3 — Percentage of patients with non-bacterial illness receiving antibiotics

Though the sample was small and restricted to chart material alone, the data indicate that a pediatrician who is conscientious in his treatment of one childhood ailment may be conscientious in his treatment of all common childhood infectious diseases. Physicians who appropriately prescribed antibiotics also obtained throat cultures more frequently and followed up otitis media more regularly than those who prescribed inappropriately. The performance of the criteria does require some extra effort: having healthy children return for checkups, resisting pressures to prescribe needless medications, and reading culture plates.

## Bibliography

1. Rapkin RH: Which pediatricians take throat cultures? What is done with the information? *Clin Peds* 11:618, 1972.
2. Breese BB: Culturing beta hemolytic streptococci in pediatric practice—Observation after twenty years. *J Pediatr* 75:164, 1969.
3. Ruben RJ: In Barnett HL and Einborn AH: *Pediatrics*. Edition 15, New York, Appleton-Century Crofts, 1972, p 1887.
4. DuPont HL and Hornick RB: Adverse effect of lomotil therapy in shigellosis. *JAMA* 226:525, 1973.
5. Soyka LF, Robinson DS, Lachant N, *et al*: The misuse of antibiotics for treatment of upper respiratory infections in children. *Pediatr* 55:552, 1975.
6. Osborne CE and Thompson HC: Criteria for evaluation of ambulatory child health care by chart audit: Development and testing of a methodology. *Pediatr* 56:625, 1975.
7. Mortimer EA Jr: Role of the pediatrician in rheumatic fever control. *Pediatr* 47:1, 1971.
8. Gordis L, Lilienfeld A and Rodriguez R: Studies in the epidemiology and preventability of rheumatic fever. *III Public Health Rep.* 84:333, 1969.
9. Markowitz M and Gordis L: *Rheumatic Fever*, Edition 2. Philadelphia, W.B. Saunders Co., 1972.
10. Jackson, GG: Perspective from a quarter century of antibiotic use. *JAMA* 227:634, 1974.
11. Ruben RJ: In Ferguson CF and Kendig EL Jr: *Pediatric Otolaryngology*. Philadelphia, W.B. Saunders Co., 1972, p 878.
12. Portnoy BL, Pruitt D, Rodriguez JJ, *et al*: Efficacy of anti-diarrheal agents in the treatment of acute diarrhea in children. *Abstracts 15th Interscience Conference On Antimicrobial Agents And Chemotherapy*, 1975, p 43.

275 Greenbrook Road, Green Brook

*A study contrasting two hospitalized patient populations with active disease in New Jersey was conducted during 1973. Fifty bacteriologically-confirmed cases of pulmonary tuberculosis in Newark, New Jersey and 50 similarly confirmed hospitalized cases were studied in Bergen County. Data on family and medical history, smoking habits, occupational and nutritional habits were collected using a bedside interview. The Newark patients were found to be significantly younger, more often black, frequently unemployed or employed in occupations requiring a minimum of occupational skills. Bergen's patients were most often employed in white collar or sales and small shop work. The Newark patients commonly migrated there from the southeastern United States, while Bergen patients often moved to New Jersey from the northeastern states and Europe. Newark patients demonstrated significantly more intra-urban transiency and mobility, while the Bergen patients were more stable and residentially immobile. A family history of tuberculosis was reported more often among the Bergen County patients. Histories of community contact with the disease suggest clustering of diseased persons, particularly in Bergen County. Large particulate, occupational exposures were acknowledged as more irritating to the Newark patients whereas small particulate exposures were found to be more irritating among Bergen County patients. Both patient populations showed evidence of severe depletion of protein and calorie stores at admission to the hospital with active tuberculosis.*

## Active Tuberculosis in New Jersey

### A Contrast in Affluence

**W. M. Lednar, Ph.D., Washington, D.C.,  
P. Stamps, Ph.D. and H. Peters, Ph.D.,  
Amherst, Ma., J. Goggin, D.V.M.,  
Burlington, Vt., R. R. Little, M.D.,  
Paramus, M. A. Quinones, Ph.D. and  
D. B. Louria, M.D., Newark\***

Tuberculosis is an infectious disease whose morbidity and mortality have rapidly declined in the past century. In the last twenty years alone, new active case rates of tuberculosis have been reduced in the United States from 49.3 per 100,000 population in 1954 to 14.2 per 100,000 in 1974.<sup>1</sup> In 1973, New Jersey ranked 19th in the United States with a new active rate of 14.6 per 100,000, an experience slightly better than the U.S. case rate of 14.8 per 100,000.<sup>1</sup> In 1973 New Jersey reported 1,075 new active cases of tuberculosis. This incident case volume places considerable demand upon the available medical care resources.

The decline in tuberculosis has been experienced in every segment of the population; however, pockets of tuberculosis appear to be persisting, especially in large, urban centers. Annual case rates of tuberculosis in the 58 largest U.S. cities have been at least twice that observed in other

areas (1963-1973).<sup>2</sup> Almost one-half of all of the TB cases in the United States in 1973 were reported in cities of 100,000 or more population.<sup>2</sup> As urban size increased, so also did the new active case rate of tuberculosis. Newark, New Jersey had the highest new active tuberculosis case rate in 1973 among the largest U.S. cities. This rate was 58.0 per 100,000 population and far exceeded the rate of 25.7 per 100,000 population reported among the 58 cities of 250,000 population or greater.<sup>3</sup> Even within Newark, rates of tuberculosis have been observed to vary among the wards in the city with the greatest concentration in the center of the city.<sup>4</sup>

Since Newark ranked number one in rates of new active tuberculosis in 1973, a study was initiated to identify those environmental and sociodemographic factors which contributed to the excess rates of tuberculosis reported in Newark.

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\*Dr. Lednar is with the Office of Allied Health Programs, The George Washington School of Medicine, Washington, D.C.; Drs. Stamps and Peters are with the School of Health Sciences of the University of Massachusetts at Amherst; Dr. Goggin is associated with the University of Vermont School of Medicine, Burlington, Vermont; Dr. Little is on the staff at Bergen Pines County Hospital, Paramus; and Drs. Quinones and Louria are affiliated with the New Jersey Medical School of the College of Medicine and Dentistry of New Jersey at Newark.



This study compared two hospitalized patient populations with markedly different socioeconomic characteristics in an effort to identify similarities and dissimilarities among tuberculosis patients living in two adjacent counties.

## Design and Methods

Newark is a densely populated, urban area in Essex County which, at the time of the study, had the highest rates of active tuberculosis in the nation. An adjacent county was desired to contrast the experience of tuberculosis patients prior to admission to the hospital with active disease. In order to make this contrast as distinct as possible, Bergen County was selected as the site for recruitment of the second tuberculosis patient population. Bergen County is a predominantly affluent, suburban residential area with rates of tuberculosis which were far below those observed in Newark.

A large teaching hospital serving the medically indigent was chosen for the identification of the tuberculosis cases in Newark. Fifty consecutively admitted and bacteriologically confirmed patients with active pulmonary tuberculosis were identified and data on family and medical history, smoking habits, occupational exposures and nutritional indicators were ascertained by bedside interviews. During the same period, 50 consecutive tuberculosis patients hospitalized with bacteriologically confirmed active tuberculosis in a community hospital in Bergen County were identified as the referent group for comparison. The same interview schedule was used among these patients. The data reported in the study were collected during the calendar year starting July, 1972. The patients interviewed in this study included those with newly diagnosed tuberculosis and patients whose disease had been diagnosed prior to the hospital admission.

Analyses of the differences observed between the patients in Newark and Bergen were statistically evaluated using the student's t-test and chi-square.<sup>6</sup> The Quetelet Index (weight/height<sup>2</sup> x 100) was calculated for each study subject as it has been demonstrated to be a useful, age-independent index of protein-calorie malnutrition and highly correlated with anthropometric

Table 1  
New Active Tuberculosis Case Rate  
By Size of Urban Areas, United States, 1973

Population Size	New Active Tuberculosis No. New Cases	Rates
500,000 +	8894	26.8
250,000 to 500,000	2692	22.8
100,000 to 250,000	2577	16.4
All other areas	16,835	11.3
Total, United States	30,998	14.8

Source: Center for Disease Control: Reported Tuberculosis Data 1973, DHEW Pub. No. (CDC) 76-8201, 1974.

measures of adiposity.<sup>7</sup> A stepwise multiple regression with a dummy-dependent variable was a multivariate technique used to evaluate the contribution of several independent variables simultaneously in an attempt to contrast these two patient groups.<sup>8</sup>

## Results

The sociodemographic characteristics of the two patient groups are presented in Table 2. Hospitalized tuberculosis patients in Newark were found to be significantly younger at admission than their counterparts in Bergen County ( $p < .001$ ). The majority of tuberculosis cases in Newark were nonwhite, whereas 76 per cent of Bergen County's cases were white. In 1970, only 3.3 per cent of Bergen County's populace and 56.0 per cent of Newark's population were non-white (predominantly black).<sup>9</sup> Thus, the nonwhite segment of the population was over-represented among the tuberculosis cases in both areas. The racial distribution between the tuberculosis groups was statistically significantly different ( $p < .001$ ). Males formed the majority of both groups with a slightly greater proportion of females among the Bergen patients. An examination of the marital status differences between the groups showed the Newark cases to have been single (never married) or separated more frequently; far fewer patients were married at the time of admission to the hospital with active tuberculosis. The larger proportion of widowed Bergen patients may have been due to their older age compared to the Newark patients. Thus, Newark patients much more commonly lived in some state of marital dissolution (separated, widowed or

Table 2  
Sociodemographic Characteristics  
of Tuberculosis Patients

Sociodemographic Characteristics	Newark		Bergen		Significance Test*	
	N	%	N	%	Test	p-value
TOTAL	50	100.0	50	100.0		
1. Age of admission (yrs) (mean & S. E.)	39.88	1.55	50.06	2.13	$\bar{t}$	.001
2. Race					$\chi^2$	.001
White	4	8.0	38	76.0		
Nonwhite	46	92.0	12	24.0		
3. Sex					$\chi^2$	N.S.
Male	39	78.0	32	64.0		
Female	11	22.0	18	36.0		
4. Marital Status					$\chi^2$	.03
Single, never married	17	34.0	12	24.0		
Married	14	28.0	26	52.0		
Divorced	2	4.0	2	4.0		
Separated	14	28.0	4	8.0		
Widowed	3	6.0	6	12.0		
5. Education					$\chi^2$	.003
9th or less	25	50.0	23	46.0		
10th-12th grades	24	48.0	16	32.0		
Some college	1	2.0	11	22.0		
Years of Education (mean and S. E.)	8.74	0.43	10.24	0.47	$\bar{t}$	.02

\*Categorical comparisons tested statistically with  $\chi^2$

Continuous comparisons tested statistically with Student's  $\bar{t}$  test

divorced) prior to admission than did the Bergen County tuberculosis patients. Bergen County patients also were found to be better educated than the Newark cases ( $p < .02$ ).

The distribution of patients by region of birthplace is presented in Table 3. The most striking differences emerge in the proportions of Newark cases who were born in the southeastern states (particularly North and South Carolina) and who subsequently migrated north to Newark. In contrast, many of the Bergen tuberculosis patients moved there from the northeastern United States and Europe (particularly the eastern European countries). Thus, migration into Newark or Bergen County appears to be common to both groups, although from markedly different areas ( $p < .001$ ).

An examination of the mobility indicators of residence time in Newark or Bergen County and transiency once residing in these areas is illustrated in Table 4. The majority of both groups lived in their respective areas for more than 10 years with sizable proportions residing 20 years or more in Newark or Bergen County. This apparent similarity, however, disguises the

Table 3  
Distribution by Birthplace

Birthplace	Newark		Bergen	
	N	%	N	%
New Jersey	7	14.0	16	32.0
Other Northeast	3	6.0	16	32.0
Southeast	36	72.0	9	18.0
Other U. S.	4	8.0	3	6.0
Europe	0	0.0	6	12.0
Total	50	100.0	50	100.0

Significance Test:  $\chi^2$ ,  $p < .001$

States included in:

Other Northeast — Massachusetts, Connecticut, New York, Pennsylvania, Maryland

Southeast — Virginia, North and South Carolina, Georgia, Alabama, Florida

Other U. S. — West Virginia, Tennessee, Illinois, Alaska

Europe — Yugoslavia, Spain, Greece, Czechoslovakia, Poland, Switzerland

intra-urban transiency characteristics of the Newark tuberculosis patients, few of whom remained in the same residence five years or more. The difference in average length of time spent at the last residence prior to admission was highly significant ( $p < .001$ ). Even the Bergen cases showed a large and mobile proportion

Table 4  
Mobility Indicators

Duration of Residence	Newark		Bergen		Significance Test p-value	
	N	%	N	%		
TOTAL	50	100.0	50	100.0		
1. Time (yrs) in Newark or Bergen Prior to Admission					X <sup>2</sup>	.05
0-4 years	2	4.0	11	22.0		
5-9 years	12	24.0	6	12.0		
10-19 years	19	38.0	9	18.0		
20 or more years	17	34.0	24	48.0		
Mean (years) and S. E.	17.12	1.56	21.64	2.63	t	N.S.
2. Time (yrs) of most recent Residence Prior to Admission					X <sup>2</sup>	.001
Less than 1 year	15	30.0	5	10.0		
1-4 years	25	50.0	14	28.0		
5-9 years	5	10.0	11	22.0		
10 or more years	5	10.0	20	40.0		
Mean (years) and S. E.	3.66	0.69	13.94	2.22	t	.001

with 38 per cent of this group having changed residences within the five years prior to admission.

Newark, as a high prevalence area for tuberculosis, was expected to provide a greater likelihood for community contact with tuberculosis for its residents. Bergen County, on the other hand, was expected to provide far fewer opportunities for community contact with the disease. Bergen patients had a significantly greater proportion with a family history of tuberculosis than Newark patients ( $p = .04$ ). Thirty-six per cent of the Bergen County cases acknowledged a family member (parent and/or sibling) to have had tuberculosis. Quite unexpectedly, the acknowledged community contact with the disease was similar between the two groups. Considering the differences between Newark and Bergen County in incidence and prevalence of TB, it was surprising to find approximately one-third of each group acknowledged community contact with the disease prior to admission.

An examination of the patient's smoking habits is presented in Table 6. Bergen patients were observed to have slightly greater average daily cigarette consumptions than Newark cases; the difference was not significant.

Patients were asked about their usual occupation (Table 7). Newark tuberculosis patients

Table 5  
Acknowledged Contact With  
Tuberculosis Persons

Contact	Newark		Bergen		Significance
	N	%	N	%	
Total	50	100.0	50	100.0	
Family History (parents and siblings)					.04
yes	8	16.0	18	36.0	
no	42	84.0	32	64.0	
Community Contact (Newark or Bergen)					N. S.
yes	19	38.0	18	36.0	
no	31	62.0	32	64.0	

Table 6  
Smoking Habits

Daily Cigarette Consumption	Newark		Bergen	
	N	%	N	%
None	11	22.0	12	24.0
Less than 1 pack	15	30.0	6	12.0
1 pack	12	24.0	17	34.0
more than 1 pack	12	24.0	15	30.0
Total	50	100.0	50	100.0
Statistical test: X <sup>2</sup> , N.S.				

were more often employed in semiskilled occupations including factory labor, maintenance and janitorial work and construction, whereas Bergen patients more often worked in sales, small shop work and white collar jobs ( $p < .01$ ). In both groups those employed in factory work and janitorial positions reported working during the late evening and early morning hours (6 p.m.-2 a.m.). Inquiries about the duration of



Table 7  
Usual Occupation

Usual Occupation	Newark		Bergen	
	N	%	N	%
1. Semi-skilled	41	82.0	23	46.0
Factory	12	24.0	14	28.0
Maintenance & Janitorial	11	22.0	3	6.0
Construction Labor	9	18.0	3	6.0
Truck Driving	7	14.0	2	4.0
Agriculture	2	4.0	1	2.0
2. Soles and Small Shop	4	8.0	13	26.0
3. White Collar	5	10.0	14	28.0
Total	50	100.0	50	100.0
Statistical test: $\chi^2$ , $p < .01$				

unemployment prior to admission revealed that 74 percent of the Bergen County patients and only 28 percent of the Newark patients were away from work for less than a week (usually sick leave). In contrast, large proportions of the Newark cases were unemployed for one month or more with 36 percent unemployed for one year or longer prior to admission. By comparison, 12 percent of the Bergen cases were unemployed for one year or longer and each of these cases were among the less socioeconomically advantaged Bergen County cases.

Patients were asked to identify agents encountered during their occupational history which they subjectively perceived as irritating to their respiratory tract. When agents were categorized by estimated particle size, Newark patients

Table 8  
Duration of Unemployment  
Prior to Admission

Length of Unemployment	Newark		Bergen	
	N	%	N	%
Less than 1 week	14	28.0	37	74.0
1 week - 3 weeks	3	6.0	4	8.0
1 month - 3 months	6	12.0	0	0.0
4 months - 1 year	9	18.0	3	6.0
more than 1 year	18	36.0	6	12.0
Total	50	100.0	50	100.0
Statistical test: $\chi^2$ , $p < .01$				

more commonly found large particulate exposures (for example sheet rock, silica, paper dust and asbestos) irritating whereas Bergen tuberculosis patients found small particulate exposures more irritating (for example diesel, kerosene and acid fumes). These differences in proportions were judged to be statistically significantly different ( $p < .01$ ).

A weight and nutritional history was taken on each patient in the study. Self-estimates of weight have been found to be highly correlated with scale weights,<sup>10</sup> where deviant, self-estimates of lighter persons tended to overestimate their scale weight.<sup>11</sup> Newark tuberculosis patients were observed to report significantly heavier usual weight than Bergen patients ( $p < .05$ ). This difference may be the result of the larger proportion of females among the

Table 9  
Acknowledged Occupational Exposure  
to Substances Judged\* to be Irritating

Irritating Substances	Newark			Bergen	
	N	%		N	%
1. Large Particulate - dust	25	50.0	13		26.0
Linen dust	2	4.0		4	8.0
Fiberglass, asbestos	3	6.0		0	0.0
Sheet rock, silica	6	12.0		3	6.0
Machine grinding dust	3	6.0		2	4.0
Paper dust	10	20.0		2	4.0
Smoke, ash	1	2.0		2	4.0
2. Small Particulate - fume	5	10.0	16		23.0
Tar, rubber	1	2.0		2	4.0
Diesel, Kerosine	2	4.0		7	14.0
Acid	2	4.0		7	14.0
3. No Irritants Contacted	20	40.0	21		42.0
Total	50	100.0		50	100.0

\*Irritating occupational exposures as subjectively judged by the tuberculosis patient

Statistical test (categories of exposures):  $\chi^2$ ,  $p < .01$

Bergen patients. These differences are, of course, speculative due to the inherent inaccuracy in self-estimates of weight. Admission weights as measured in the hospital were almost identical between the two groups.

The Quetelet Index ( $\text{weight/height}^2 \times 100$ ) is a useful, age-independent index of protein-calorie malnutrition.<sup>7</sup> Skeletal muscle and subcutaneous fat are the most depleted tissues in protein-calorie malnutrition with bony measurements affected very slightly.<sup>12</sup> The observed Quetelet Indices (at admission) are similar between the two groups of tuberculosis patients and indicative of depletion in body stores of protein and calories. This is to be expected due to the nature of the infectious process and the bodily response. An examination of the Quetelet Index calculated using the patient's estimate of usual weight shows the Newark patients to have a significantly higher mean index than the Bergen patients ( $p < .05$ ). This comparison must be interpreted cautiously, however, due to the subjective nature of the weight component of the index. The same sex and cultural differences

may be invoked as possible explanations for the Newark patient's excess as described for usual weight above.

A multivariate model was constructed which estimated the association of a variety of the risk factors (discussed independently above) when adjusted for the contribution of other risk factors in the model. The objective of the model was to identify those risk factors which, taken together, distinguished the tuberculosis patients in Newark from those patients in Bergen County. The stepwise multiple regression with a dummy dependent variable was used to separate the two groups based upon the discriminating power of the variables in the model. The results of this analysis are presented in Table 11. Race was found to be the most important factor to distinguish statistically the two populations with the majority of Newark's cases (92 per cent) being nonwhite. This characteristic alone explained 47 percent of the variance between the groups. The time spent at the last residence prior to admission was found to be similarly significant in distinguishing the two groups.

Table 10  
*Weight History and Nutritional Status*

Weight History (pounds)	Newark (N=50)		Bergen (N=50)		Significance
	Mean	S.E.	Mean	S.E.	
Usual weight (estimated)	151.72	3.47	142.14	3.22	.05
Admission weight	127.78	4.19	127.38	3.97	N.S.
Quetelet Index* at admission	2.7	0.03	2.8	0.04	N.S.
Quetelet Index* at usual weight	3.3	0.01	3.1	0.03	.05

\*Weight/Height<sup>2</sup> X 100

Table 11  
*Multivariate Model for  
the Identification of  
Two Tuberculosis Populations*

Variable	Multiple R	R Square
Race	.6889	.4746
Years at last residence	.7117	.5064
Birthplace	.7173	.5145
Years of education	.7219	.5212
Quetelet Index at usual weight	.7271	.5287
Quetelet Index at admission	.7586	.5604
Community TB contact	.7539	.5683
Time in Newark or Bergen	.7563	.5720
Irritating Occupational Exposures	.7584	.5751
Age	.7603	.5781
Family History of Tuberculosis	.7626	.5815

Bergen cases were less mobile and transient spending more time at their most recent residence prior to admission than Newark's TB patients. Birthplace entered the model third with migration from the southeastern states being particularly effective in discriminating between the groups. As can be observed by changes in the R-Square column, the addition of other variables in the model, although statistically significant, added little to one's ability to differentiate between the two tuberculosis patient groups.

### Discussion and Summary

A large number of variables were found to be statistically, significantly different between these two similarly diseased groups. Although infection with the same organism, *Mycobacterium tuberculosis*, diagnostically confirmed the disease, the social and environmental factors which characterized the pre-admission experience of these two groups were quite different. In Newark, the hospitalization with tuberculosis occurred at a significantly younger age. In Bergen, tuberculosis is more commonly encountered among the middle-aged and elderly age groups whose defenses against infection or reactivation are diminished. The racial composition of the two groups is markedly different yet, in each population, nonwhites (predominately blacks) are over-represented. Newark's patients often are found to be under social stresses such as marital dissolution, poor education with minimal occupational skills or seniority, migration to northern urban areas in search of employment with consequent family separation, and frequent residential moves once residing in Newark.

Somewhat more reflective of the county's affluence and economic stability, the patients from Bergen are less mobile, employed in sales and white collar jobs more often, they are more continuously employed and exhibit far fewer residential changes prior to admission. For both groups, the hospitalization with active disease did not occur soon after a residential move into Bergen County or Newark, but rather occurred after a considerable length of time in the areas. Family history of tuberculosis was more

than twice as common among the Bergen patients as observed in Newark. The older Bergen patients, living in low tuberculosis prevalence areas, are more likely to be reactivators of a latent infection derived from an earlier exposure in a high prevalence area or during a time period when the disease was encountered more frequently in the community (e.g., 1920-1940). Of interest, however, was the finding that the younger patients in Bergen County acknowledged pre-admission community contact with the disease more often than the older Bergen patients. Although the prevalence of TB in Bergen County is low, this rate may mask the existence of pockets of infection within the county, particularly in the relatively less affluent areas. The Newark cases, however, are younger and often have left the more rural areas of the southeastern U.S. in search of employment in Newark. This high prevalence, socio-economically depressed urban area may provide the milieu for new infection with the disease. Alternatively, these patients, if infected in their birthplace regions, may break down and develop active disease when placed under the environmental hardships they frequently encountered prior to admission. Both groups demonstrated severe depletion of protein and calorie stores at admission as estimated by the Quetelet Index.

When taken together, these factors point to the need for screening the more transient and mobile segments of the community for the presence of tuberculosis infection. The data in this study indicate that whether the effort toward tuberculosis control is conducted in the inner city or the more affluent suburbs, residence mobility may be associated with an increased occurrence of tuberculosis infection. Risk estimate profiles can be designed to identify those individuals at greater risk of either new infection or reactivation of a previously established focus of infection. Such high risk individuals then can be followed periodically through the usual public health control programs. Culturally appropriate programs may be the critical factor necessary in the identification of infected persons (with or without manifest symptoms). The application of intensive patient and community education programs



adapted for the specific needs of the urban or suburban locale will help acquaint the community with the disease, encourage medical attention and facilitate follow-up, particularly as the population ages.

## References

1. Center for Disease Control: 1974 Tuberculosis Statistics: States and Cities, DHEW Pub. No. (CDC) 76-8249, 1975.
2. Center for Disease Control: Reported Tuberculosis Data 1973, DHEW Pub. No. (CDC) 75-8201, 1974.
3. Center for Disease Control: 1973 Tuberculosis Statistics: States and Cities, DHEW Pub. No. (CDC) 75-8249, 1974.
4. Quinones MA, Louria DB, Foster JD and Lednar WM: Tuberculosis in Newark. *J Med Soc NJ* 72:419-421, 1975.
5. Lednar WM, Quinones MA, Louria DB, Peters HA, Stamps P and Goggin J.: Active tuberculosis among the inner city indigent: Perspective on the 1970's. *J Med Soc NJ* 74:517-523, 1977.
6. Dixon WJ and Massey FJ, Jr.: *Introduction to Statistical Analysis*. New York, McGraw-Hill, 1969.
7. Committee on procedures for appraisal of protein-calorie malnutrition of the international union of nutritional sciences: Assessment of protein nutrition status. *Am J Clin Nutr* 23:807-819, 1970.
8. Snedecor GW and Cochran WG: *Statistical Methods*. 6th edition. Ames, Iowa, Iowa State University Press, 1967.
9. U.S. Department of Commerce: 1970 Census of the Population. General Population Characteristics: New Jersey. Bureau of the Census, Washington, D.C., 1974.
10. Perry L and Larnard B: Obesity and mental health. *JAMA* 183:807, 1963.
11. Damon A: Adult weight gain, accuracy of stated weight and their implications for constitutional anthropology. *Am J Phys Anthropol* 23:306-311, 1965.
12. Jelliffe DB and Jelliffe EFP: Age independent anthropometry. *Am J Clin Nutr* 24:1377-1379, 1971.

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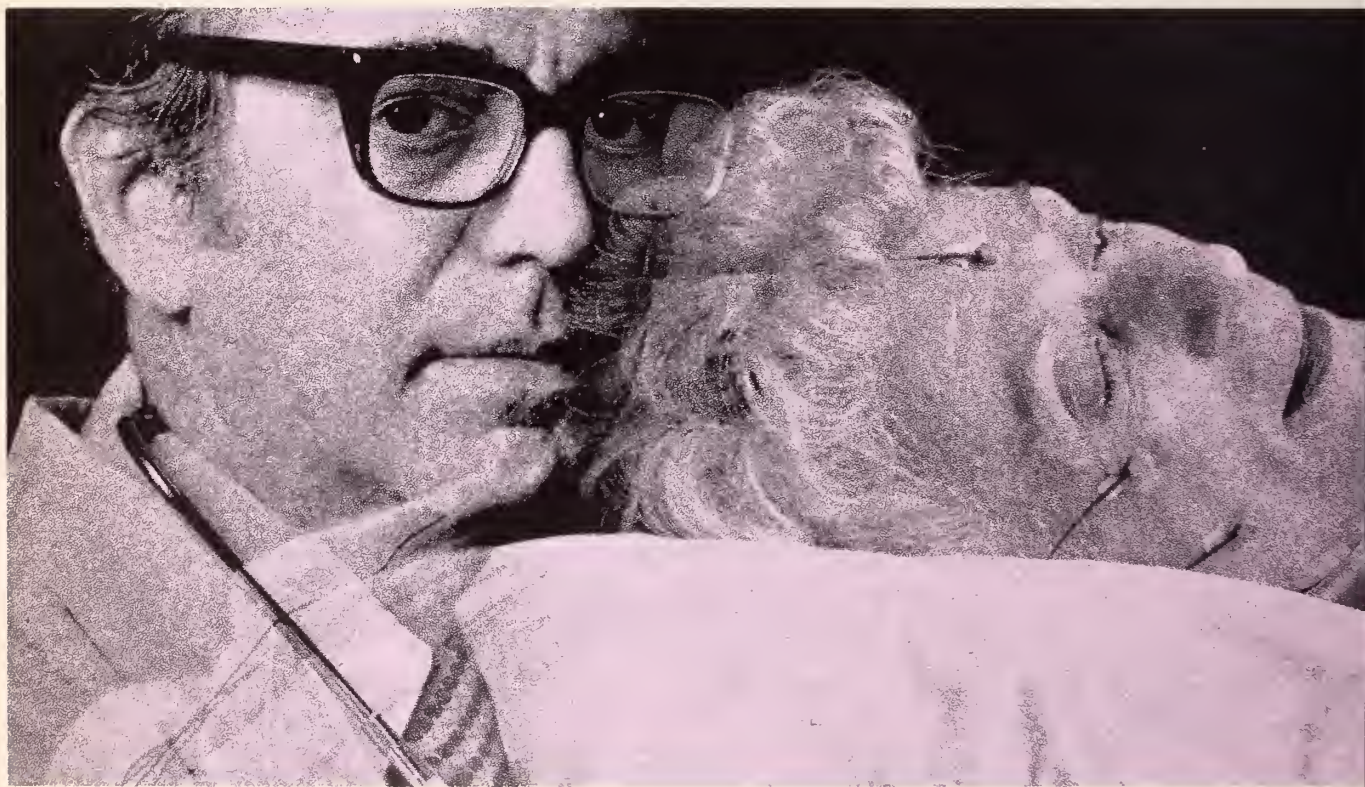
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### References:

1. Kales A, et al: *Arch Gen Psychiatry* 23:226-232, Sep 1970
2. Kales A, Kales JD, Martin ED: *Drug Ther* 5:31-39, Jun 1975
3. Kales A, Kales J: Recent advances in the diagnosis and treatment of sleep disorders, in *Sleep Research and Clinical Practice*, edited by Usdin G. New York, Brunner/Mazel Inc., 1973, p. 61

4. Robinson DS, Amidon EL: Interaction of benzodiazepines with warfarin in man, in *The Benzodiazepines*, edited by Garattini S, Mussini E, Randall LO. New York, Raven Press, 1973, p. 641

5. Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ

6. Young DS, Pestaner LC, Gibberman V: *Clin Chem* 21:110-432D, Apr 1975

7. Moore JD, Weissman L: *J Clin Pharmacol* 16:241-244, May-Jun 1976

8. Spiegel HE: Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ

9. Kaplan SA, et al: *J Pharm Sci* 62:1932-1935, 1973



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# CASE REPORTS

*Aneurysm of the splenic artery has a high mortality rate, especially in the young pregnant female. Most series report a mortality of 76 percent in this otherwise healthy group. This successfully treated case should alert others to the value of prompt angiography and surgical intervention.*

## Ruptured Splenic Artery Aneurysm

**William A. Dwyer, Jr., M.D.,  
James A. Valenza, M.D., and  
Thomas A. Howe, M.D., Paterson**

Although second only to aortic aneurysms in frequency, spontaneous splenic artery aneurysms are considered a rare surgical disease. Among reports of more than 800 patients with splenic artery aneurysms, only two studies of more than 20 cases have been reported for a single institution.<sup>1</sup> When rupture occurs, it becomes a lethal entity. In one collective review of 204 cases, the authors report 94 cases of aneurysmal rupture with a mortality of 76 percent.<sup>2</sup>

This paper describes the authors' experience with a patient with this particular surgical problem, which was treated successfully. We hope to aid others in reducing the mortality now commonly associated with this disease.

### Historical

This lesion was first described by Beaussier in 1770.<sup>3</sup> Hogler, in 1920, is responsible for the first preoperative diagnosis based on the existence of an audible bruit and a pulsatile mass on fluoroscopy. In 1965, Baum introduced preoperative selective angiography into the diagnostic armamentarium.<sup>4</sup>

### Case History

A 29-year-old female, gravida II, para I, was admitted to the emergency room on October 3, 1976, two weeks post partum, with complaints of a sudden onset of syncope after defecation. Two days prior to admission she had episodes of nausea and abdominal cramping with diarrhea, but without melena. Her medical history was unremarkable except for allergy to penicillin. She had an appendectomy eight years ago and had undergone tubal ligation immediately after the birth of her child two weeks prior to this episode.

On admission she was extremely pale with cold and clammy

skin. She complained of minimal abdominal pain. The pulse was weak and thready; blood pressure was 160/60 but dropped to imperceptible levels within minutes of the initial reading. There was abdominal tenderness but no rebound present. Liver and spleen were not palpable. No abdominal bruit was heard. On rectal examination, the patient was found to have mahogany-colored stool. Apart from a fresh infraumbilical operative incision and a torn earlobe, (patient had caught her earring on a bathroom fixture when she fainted), the remainder of the physical examination was normal. Her admission blood count was: Hgb. 10.4, Hct. 30.5, RBC 3.38, WBC 18,600, 63 neutrophils with 3 stab forms, blood typing A+. Urinalysis was negative. Stool was strongly positive for occult blood.

The blood pressure rose to approximately 80 systolic with infusion of Ringer's lactate solution and administration of one unit of type specific whole blood; she was transferred to the intensive care unit where a nasogastric tube and Foley catheter were inserted.

The patient obviously was bleeding profusely, presumptively from the gastrointestinal tract in view of the blood in the stool. Therefore, selective angiography to pinpoint the source of blood loss was requested. While awaiting the procedure, the operating room staff was mobilized and transfusions of whole blood were continued. Systolic blood pressure at this time was 100 and the patient had a satisfactory urinary output. Additional amounts of blood were obtained from the area blood bank and two bags of fresh frozen plasma were thawed, one of which was given while angiography was being carried out. Within 90 minutes of admission, selective angiography was performed and revealed a large splenic artery aneurysm with an arteriovenous communication.

The blood pressure suddenly dropped again as the films were being viewed. The patient was brought immediately to the operating room and laparotomy was performed within three hours after admission to the hospital.

Approximately 3,000 cc. of blood had entered the peritoneal cavity from a ruptured splenic artery aneurysm. The splenic artery was compressed manually while the blood pressure was restored to normal levels. Splenectomy then was performed. The entire gastrointestinal tract was examined and no other source of bleeding was encountered. At the conclusion of the procedure, the patient's blood pressure was 120/80 and her pulse was 100.

The patient received approximately 5,500 cc. of Ringer's lactate solution and 2,000 cc. of whole blood pre-operatively. She received one unit of fresh frozen plasma prior to surgery and one unit during surgery. The estimated blood loss at the end of the operation was calculated to be approximately 5,000 cc. One ampule of sodium bicarbonate (44 milliequivalents) and 500 mg of hydrocortisone were





Figure 1—Arterial phase angiogram showing splenic artery and aneurysm.



Figure 2—Venous phase angiogram showing aneurysm, splenic vein, and spleen.

administered intravenously shortly after admission to the intensive care unit.

The postoperative course was complicated by a fever of 103° on the first two days. Chest x-ray showed a left lower lobe infiltrate. This responded to administration of intravenous Keflin® and ultrasound nebulizer treatment. She also was given an additional 100 mg. of hydrocortisone on the first postoperative day. Her course was otherwise uncomplicated and she was discharged ten days after admission.

Pathology report indicated that the spleen weighed 200 gm. The aneurysm, measuring 2.0 cm., was located next to the splenic capsule; there was a small defect in the wall which was occluded by a firm thrombus. On microscopy the elastic lamina was present in some areas and absent in others, there was extensive clot formation seen on the endothelial surface.

## Discussion

The splenic artery is the largest, most elongated, and tortuous artery arising from the celiac axis. It is the most common site of intra-abdominal aneurysm exclusive of the aorta.<sup>5</sup>

The exact incidence of splenic artery aneurysm is not certain. Most of the data are reported from autopsies and vary from 1.02 to 0.16 percent in most series.<sup>5</sup> Ferrari reported a group of autopsies restricted to people over age 60 in whom the incidence was ten percent.<sup>4</sup> In 1953, Owens and Coffey,<sup>2</sup> reporting on a total of 204 cases, noted that splenic artery aneurysms (in contrast to other aneurysms) are more prevalent in the female than in the male with a ratio of five to one. Fifty percent of splenic artery aneurysms occur in the childbearing age. Of this latter group, 53 percent of the patients were pregnant when the aneurysm was discovered.<sup>4</sup>

Just as the incidence of splenic artery aneurysm varies, so do the etiological factors. Arteriosclerosis appears to be the most common cause followed by congenital defects in the arterial wall. Trauma, portal hypertension, systemic hypertension, and pancreatitis recently have been linked with splenic artery aneurysm. Syphilis, though rare at present, also has been incriminated as a factor. A study of 60 patients with splenic artery aneurysms from the University of Michigan Medical Center categorized the etiological factors relevant to these aneurysms into five groups.<sup>1</sup> (1) arterial dysplasia, (2) portal hypertension and splenomegaly, (3) focal arterial inflammatory processes, (4) hormonal and hemodynamic factors in parous females, (5) aneurysms unassociated with clearly recognizable pathogenic factors.

The relationship between pregnancy and splenic artery aneurysm is interesting. The mechanism which influences rupture is not completely known, but changes in the mucopolysaccharides which accompany pregnancy may play a role. A survey of English medical literature from 1960 to 1970 reports that 45 percent of splenic artery aneurysms have been found in grand-multiparous females.<sup>1</sup> Repeated pregnancies may produce irreversible damage to vessels such as the splenic artery.

Rupture most commonly occurs in the last trimester of pregnancy and rarely in the puerperium.<sup>6</sup> The maternal mortality is reported to be as high as 80 percent and the fetal mortality up to 92.5 percent.





Figure 3—Gross specimen showing aneurysm with intra-luminal clot closely associated with spleen below it.

Most splenic artery aneurysms are silent. Rupture was the first sign of the aneurysm in 46 percent of the patients in one series. "Double rupture," i.e., the tendency for these aneurysms to first "leak" and then completely rupture several days later, was first described by Brockman in 1930. It is recognized in about 50 percent of the patients. Characteristically cramping abdominal pain associated with weakness and dizziness appear hours or days before shock and stupor due to secondary hemorrhage and exsanguination. Splenomegaly has been reported in about 40 to 50 percent, palpable mass in the left upper quadrant in only 20 percent, and pulsations or bruit in 10 percent. Less frequently, rupture into the stomach, colon, pancreas, pancreatic duct, left pleural space, and splenic and renal veins has been reported.<sup>7</sup> A roentgenogram of the abdomen reveals an annular calcification in the left upper quadrant in 15 percent of the cases. Selective angiography is usually necessary, as it was in our own case. Ghatan, *et al.* reported a patient in whom angiography helped to localize an aneurysm of an anomalous splenic artery found to arise from

the superior mesenteric artery.<sup>5</sup> Failure to visualize an aneurysm does not necessarily rule out its presence as it may be filled with laminated thrombus. It also is recommended that celiac angiography be employed rather than selective splenic arteriography in order not to overlook the coexistence of other intra-abdominal aneurysms.

The management of splenic artery aneurysms in asymptomatic patients is a subject of surgical controversy. Close observation and follow-up are recommended in selected cases in the older age groups. De Bakey recommends resection of all aneurysms if the patient is a good surgical risk.<sup>5</sup> Practically all authors agree that any woman of child-bearing age, with or without symptoms, should have surgical treatment upon diagnosis. Splenectomy with resection of the aneurysm is the procedure of choice. Occasionally, the aneurysm is more proximal and, in these cases, proximal and distal ligation of the splenic artery is advocated. In such cases, the tail of the pancreas may have to be resected with the aneurysm.

## References

1. Stanley JD, *et al*: Pathogenesis and clinical significance of splenic artery aneurysms. *Surg* 76:898-909, 1974.
2. Owens JC, Coffey RJ: Collective review: Aneurysm of splenic artery including report of six additional cases. *Int Abst Surg* 97:313-315, 1953.
3. Puga F, *et al*: Preoperative diagnosis and treatment of a splenic artery aneurysm ruptured into the stomach. *Am Surg* 36:473-476, 1970.
4. Thirugnam A, *et al*: Ruptured splenic artery aneurysms: Review of literature and presentation of two cases. *Vasc Surg* 7:269-275, 1973.
5. Saw EC, *et al*: Splenic artery aneurysm. *Arch Surg* 106:660-662, 1973.
6. Baird MA: Rupture of a splenic artery aneurysm in pregnancy. *Proc R Soc Med* 66:762-763, 1973.
7. Hootkin LA, *et al*: Ruptured splenic artery aneurysm with resultant upper GI bleeding. *Am J Dig Dis* 15:848-850, 1970.

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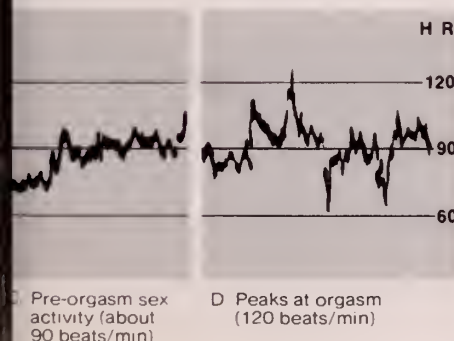
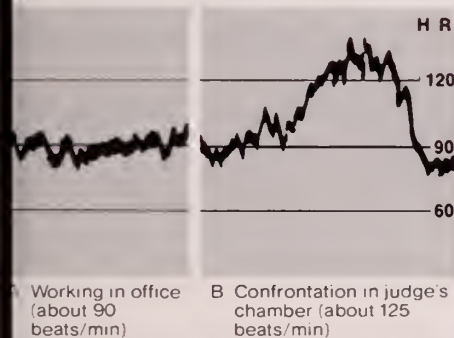
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*Gastrointestinal symptoms in patients with systemic lupus erythematosus may be caused by transient ischemia to the bowel. While physical findings are only suspicious for this diagnosis, characteristic findings with barium studies of the gastrointestinal tract secure the diagnosis. Because the ischemia is often reversible, medical rather than surgical therapy is the treatment of choice.*

## Transient Ischemia of the Small Bowel Secondary to Lupus Vasculitis

**Alan J. Simpson, M.D., Atlantic City**

Symptoms referable to the gastrointestinal tract are quite common in patients with systemic lupus erythematosus (SLE).<sup>1,2</sup> Common complaints may include anorexia, nausea and vomiting, diarrhea, abdominal pain, and hemorrhage. Although these gastrointestinal problems may result from the necrotizing vasculitis, concurrent uremia, or steroid or anti-metabolite therapy, coincidental gastrointestinal disorders such as gastritis, ulcers, pancreatitis, biliary tract disease, appendicitis or hepatitis also may be responsible for similar symptoms. Thus, the problem in differential diagnosis is to separate lupus-related causes of gastrointestinal complaints from other conditions and to define the specific disorder with the lupus spectrum.

Abdominal pain and post-prandial fullness are two symptoms which in association with the physical findings of abdominal tenderness, rebound tenderness and guarding in a patient with SLE, are highly suspicious for ischemic vasculitis involving the gut.<sup>3</sup> Moreover, characteristic findings on an upper gastrointestinal series secure the diagnosis. A recent encounter with such a patient prompted this report.

### Case Report

A 45-year-old male with known systemic lupus erythematosus for 12 years was hospitalized with complaints of abdominal pain and cramps in the calves. For three years prior to admission he had experienced intermittent diffuse abdominal pain and bloating unrelated to meals. Two weeks before admission, he suddenly experienced nausea and vomiting followed by crampy pain localized to the epigastrium. This subsided in one day, but two days prior to admission, following dinner, he experienced a second, more severe episode of pain, nausea, and vomiting. A small amount of blood was noted in the vomitus and this

prompted his hospitalization. The patient had a long history of numbness and coolness of his legs and had two previous hospitalizations for treatment of leg ulcers and skin grafting secondary to lupus vasculitis. Two weeks prior to this admission he experienced intermittent cramps in his buttocks, thighs, and calves; they were worse at night and were aggravated with walking. Current treatment included 10 mg. of prednisone per day.

Physical examination revealed a red rash over the nasal bridge. The patient's abdomen was soft, however there was guarding just to the right of the mid-epigastrium without rebound tenderness. There were swan neck deformities and deviation of the fingers. Purpura was present over the body, especially the buttocks and legs, with a few larger ecchymoses over the left lower leg and thigh. There were diminished dorsalis pedis and posterior tibial pulses particularly on the left side, associated with cyanosis of the left first toe and an ulcer involving the left fifth toe.

The laboratory studies were as follows: The Hema<sup>®</sup> test was negative. The LE prep and the latex test were both positive. The ANA test was positive (1:320). The RA latex test was positive with 1:20 dilution. SMA-12, amylase, complete blood count, prothrombin time, and partial thromboplastin time were within normal limits. IGA, IGM and IGG were normal. The creatinine clearance was 69 cc per square meter per minute. Anti-DNA was 16.9 micro units and C<sup>3</sup> complement was 105 mg/dl.

An upper gastrointestinal series revealed localized but almost uniform thickening of the mucosal folds of the duodenum and proximal jejunum (Figure 1A and 1B). These findings were interpreted as consistent with ischemia.

The patient was treated with hydrocortisone succinate, 50 mg. intravenously every six hours and a Sippy diet. Within three days, he became asymptomatic. X-ray of the upper gastrointestinal tract on the fifth day demonstrated a normal mucosal pattern (Figure 2A and 2B). The leg ulcers improved after treatment with soaks and topical antibiotics. The patient was also treated with prednisone, 80 mg. daily. He has remained asymptomatic.

### Discussion

The radiographic features of lupus vasculitis reflect the underlying pathologic process of ischemia, as they do in other types of ischemic

\*From the Department of Radiology and Nuclear Medicine, Atlantic City Medical Center.



*Figure 1A*—A supine film of the abdomen with barium in the stomach and proximal small intestine demonstrates thickening of the mucosal folds from the descending portion of the duodenum to the proximal jejunum.



*Figure 2A*—A repeat upper gastrointestinal series five days later reveals a normal study. The patient was now asymptomatic.



*Figure 1B*—A spot film from the upper gastrointestinal series shows the localized findings of ischemic changes in the proximal small intestine.



*Figure 2B*—A spot film of the duodenal sweep shows a normal mucosal pattern.

bowel disease. The layers of the bowel are not equally sensitive to a decrease in blood supply;<sup>4</sup> the mucosa is most sensitive, while the muscular layer, submucosa and serosa are progressively less so. Superficial ulceration of the mucosa of the small intestine is not apparent radiographically, however, edema and hemorrhage in the submucosa result in thickening and nodularity of the small bowel pattern. Compromise of the

circulation of the muscular layer affects peristaltic activity resulting in dilatation, pseudo-obstruction and a pattern suggesting ileus. While these findings can simulate other diseases such as regional enteritis or submucosal hemorrhage and edema from causes other than ischemia or segmental infarction, their presence in a patient with SLE should make lupus vasculitis a probable diagnosis.

While intestinal perforation or frank intestinal infarction is rare in SLE,<sup>5</sup> symptoms related to the vasculitis are more common in these patients than is probably recognized.<sup>6</sup> Often the patients are misdiagnosed as having gastritis, ulcers, obstruction or peritonitis. Prompt roentgen evaluation of the abdomen by plain films and upper gastrointestinal series with barium should be obtained, so that the changes of ischemia may be recognized. The ischemia is often reversible, and medical therapy employing steroids rather than surgical intervention is the treatment of choice in most cases.

## References

1. Brown CH, Shirey EK, Haserick JR: Gastrointestinal manifestations of systemic lupus erythematosus. *Gastroenterol* 31:649-664, 1956.

2. Dubois EL, Tuffanelli DL: Clinical manifestations of systemic lupus erythematosus. *JAMA* 190:104-111, 1964.

3. Shapeero LG, Myers A, Oberkircher PE, et al: Acute reversible lupus vasculitis of the gastrointestinal tract. *Radiol* 112: 569-574, 1974.

4. Wolf BS, Marshak RM: Segmental infarction of the small bowel. *Radiol* 66: 701-706, 1956.

5. Pollack VE, Grove WJ, Kark RM, et al: Systemic lupus erythematosus simulating acute surgical condition of the abdomen. *N Engl J Med* 259: 258-266, 1958.

6. Kleinman P, Myers MA, Abbott G, et al: Necrotizing enterocolitis with pneumatosis intestinalis in systemic lupus erythematosus and polyarteritis. *Radiol* 121: 595-598, 1976.

Atlantic City Medical Center

## Pediatric Briefs

**Less than 1000 Gram Infant: Immediate and Longterm Outcome.** Bhat, R. et al.: *Abstracts, APS-SPR*, 1977, p. 560.

One hundred such infants transferred to a neonatal intensive care unit were studied. Fifty percent of infants weighing more than 750 grams survived. Sixty-nine percent of survivors were neurologically normal at 6 to 30 months of age.

*Comment:* Intensive care of tiny premature infants has made a major difference in prognosis. Although the majority die quickly, most of the ones that survive do well, at least in a short-term follow-up. R.H.R.

**In Utero vs Postpartum Transportation of High Risk Infants.** Rapoport, P. F. et al.: *Abstracts, APS-SPR*, 1977, p. 541.

Intrauterine transport and transfer after birth were compared to test the hypotheses that "the best transport incubator is the uterus." No difference could be determined in two groups of 40 patients despite an average transportation distance of 100 miles.

*Comment:* Transport of sick neonates, when well done, may not make much, if any, difference in morbidity and mortality. Since obstetrical services will need to remain close to the patient, for obvious reasons, it is unlikely to expect total regionalization of same. Quality obstetrics and efficient and effective transfer of neonates to regional centers is a reasonable method of dealing with unpredictable obstetrical-neonatal problems. R.H.R.

Excerpts from CMDNJ-Rutgers Medical School *Pediatric Newsletter* (Vol. 1, No. 8, June 1977), Richard H. Rapkin, M.D., Editor. Dr. Rapkin has given *The Journal* permission to reprint this material from time to time.



*This paper reports three cases of advanced abdominal pregnancy and evaluates the usefulness and pitfalls of the classic diagnosis criteria and suggests an approach, including the use of ultrasonography, toward the differential diagnosis.*

## Pitfalls in the Diagnosis of Advanced Abdominal Pregnancy\*

**J. Apuzzio, M.D., M. Frattarola, M.D.,  
V. V. Gowda, M.D., T. S. Li, M.D.,  
D. Fricchione, M.D., M. A. Pelosi, M.D.,  
J. C. Sama, M.D., and H. Caterini, M.D.,  
Newark**

With an estimated incidence of one per 3,000 term gestations<sup>1</sup>, advanced abdominal pregnancy represents a diagnostic challenge in obstetrical practice. The physician presented with any female patient must always entertain a possible diagnosis of pregnancy and, to proceed one step further, the possibility of an extrauterine pregnancy should be considered especially if the pregnancy is "not normal."

This paper reports three cases of advanced abdominal pregnancy which occurred at Martland Medical Center between 1969 and 1975. In addition, this communication evaluates the usefulness and pitfalls of the classic diagnostic criteria, and suggests an approach toward the differential diagnosis.

*Case 1*—A 36 year-old nulligravida came to the emergency room and complained of lower abdominal pain of increasing intensity of two months' duration. She had had irregular menstrual periods during the previous seven months, and had recently noticed difficulty in urination and defecation. The patient attributed increasing abdominal girth to fat accumulation. On physical examination, she was in moderate distress due to abdominal pain. The abdomen was distended and rebound tenderness was elicited. An abdominal mass was palpated with its upper border extending four finger breadths above the umbilicus. Bowel sounds were hypoactive. Pelvic examination revealed the cervix to be displaced anteriorly behind the symphysis pubis; a firm slightly tender mass occupied the entire cul-de-sac. The hematocrit was 22 percent. A flat plate and lateral x-ray view (Figures 1 and 2) of the abdomen were reported as "intrauterine pregnancy, in frank breech presentation." A tentative diagnosis of advanced abdominal pregnancy was made, so an exploratory laparotomy was performed due to increasing abdominal pain. An extrauterine pregnancy with a dead fetus weighing 2 pounds 7

ounces was found. The placenta was attached to the posterior surface of the uterus and the left adnexa, hence removal of the placenta was easily accomplished along with a total abdominal hysterectomy and bilateral salpingo-oophorectomy (Figure 3).

*Case 2*—A 43 year-old female, gravida five, para four, whose last menstrual period was seven months prior to admission was admitted to Martland Medical Center with a diagnosis of "fetal demise and vaginal bleeding." The patient had been followed for two months in a prenatal clinic; during this time there was no increase in uterine size and no audible fetal heart tone. The patient experienced occasional crampy lower abdominal pain, but attributed it to "gas pain." On physical examination, the abdomen was distended due to a mass about the size of a 20 weeks' gestation. Through pelvic examination, the cervix was found to be displaced anteriorly behind the symphysis pubis and the "uterus" was enlarged to the size estimated by abdominal examination. A diagnosis of "fetal demise" was confirmed by x-ray findings of collapsed fetal skull, so



Figure 1—Radiograph of Case 1—AP view.

\*From the Department of Obstetrics and Gynecology, Martland Hospital, New Jersey Medical School, CMDNJ, Newark.



Figure 2—Radiograph of Case 1—lateral view. Note no overlapping of fetal spine and maternal spine. Arrow points to outline of amniotic sac, which was mistaken for uterine shadow.



Figure 3—Operative findings in Case 1. Placenta is in left hand of surgeon.

induction of labor was planned. Amniotomy was attempted but failed. Several attempts at Syntocinon® induction also failed to initiate labor. A cesarean section was planned because of unsuccessful induction of labor; at surgery a dead macerated fetus of 525 grams was found in the cul-de-sac along with the placenta. A total abdominal hysterectomy and bilateral salpingo-oophorectomy were performed; the placenta, which was attached to the cul-de-sac and bowel, was left *in situ*.

**Case 3**—A 30 year-old gravida two, para one patient was admitted at term with diagnosis of intestinal obstruction. The patient had severe abdominal pain, obstipation, abdominal distension, and vomiting. A term-size fetus in breech presentation with normal fetal heart tones was felt on abdominal examination. Pelvic examination revealed the

cervix to be displaced anteriorly behind the symphysis pubis; a firm mass occupied the cul-de-sac. Flat and upright abdominal x-ray films showed a fetus in breech presentation and dilated maternal bowel suggestive of intestinal obstruction. Due to increasing abdominal pain, an exploratory laparotomy was performed, and an extra-uterine pregnancy was found. A live fetus (Apgar 1) weighing 6 pounds was delivered, however the fetus could not be resuscitated and died shortly after birth.

## Discussion

The diagnosis of advanced abdominal pregnancy can be established if one proves that the patient is pregnant and that the pregnancy is extrauterine. One of the important symptoms is persistent abdominal pain which is often generalized and vague; occasionally the onset is acute. Pain was the presenting symptom in all three reported cases, and the degree of pain probably correlated best with the length of gestation and the amount of bowel compression.

Menstrual aberrations are usually present with a history of either complete amenorrhea, irregular bleeding, or scanty flow. Two of the three cases did present with a history of irregular vaginal bleeding, but case three had no abnormal vaginal bleeding.

The subjective but nonspecific symptoms of pregnancy such as nausea, vomiting, and breast tenderness may be present. A parous woman may just complain that the pregnancy is "unusual," with more discomfort than previous pregnancies. She may complain of painful fetal movements if the fetus is still alive, or of cessation of fetal movement after the fetus dies.

Exaggerated internal symptoms such as difficult or painful defecation or actual intestinal obstruction may occur along with urinary retention, dysuria, and frequency. Pressure symptoms, whose severity depended on the amount of force exerted by the abdominal mass on the bladder and rectum, were present in all three cases.

Examination of the abdomen may reveal distension due to a mass, unusual tenderness, rigidity, or rebound tenderness. A feeling of "superficiality" of the fetal parts may be pres-

ent.<sup>2</sup> These signs were present in two of the three cases; in cases two and three, the "mass" was mistaken for a normal intrauterine pregnancy. Although not found in our cases, abdominal examination may reveal an abnormal fetal presentation with the fetus being located "high" in relation to the pelvic brim.<sup>5</sup> Unusually loud fetal heart tones may be audible with a fetoscope if the fetus is still alive.

Pelvic examination may be particularly valuable, especially if anterior displacement of the cervix is present. This finding, which was present in all three of our cases, should alert the examiner to a space-occupying mass in the cul-de-sac. It is one of the most important physical signs of extrauterine pregnancy.

Laboratory tests do not help one to establish a diagnosis of advanced abdominal pregnancy. Biological or immunological tests for pregnancy may be positive or negative depending on feto-placental viability.

Radiographic examination of the maternal abdomen is considered by some authorities to be the most helpful diagnostic test. King<sup>3</sup> stated that an abdominal flat plate may suggest the diagnosis of abdominal pregnancy by demonstrating a fetus in an abnormal presentation or attitude, especially in a transverse lie with the dorsum of the fetus cephalad. Radiologic signs of fetal death may be present if the fetus is not alive, but they are not diagnostic of extrauterine pregnancy. Occasionally one may find calcifications of the amniotic sac<sup>2</sup>. Lateral roentgenograms of the maternal abdomen may demonstrate fetal parts posterior to or superimposed on the maternal spine<sup>4</sup>. Another suggestive sign is absence of the uterine shadow around the fetus<sup>5</sup>. These signs were not present in the three cases reported. In two cases, the outline of the amniotic sac was misinterpreted by a radiologist as the uterine shadow. In case one, a diagnosis of frank breech position with an intrauterine pregnancy was made by the radiologists (Figures 1 and 2). Reliance on these classic x-ray findings seems to be one of the

major pitfalls in the diagnosis of advanced abdominal pregnancy in our three cases. A hysterosalpingogram may prove to be diagnostic if a normal uterine contour separate from a fetal skeleton is demonstrated. This test should not be used if intrauterine pregnancy is a possibility, therefore it is of little value.

The pitocin test may be a valuable aid in the diagnosis of abdominal pregnancy<sup>5</sup>. This test allows the uterus to be differentiated from an abdominal mass by causing uterine contractions with pitocin stimulation. This test was performed unknowingly in case two but it did not help establish the diagnosis.

Other possible modalities to establish the diagnosis include placentography, aortography, culdoscopy, laparoscopy and ultrasonography. Ultrasonography may be diagnostic if the uterus is noted to be larger than normal and its cavity echo-free with no evidence of fetal parts<sup>6</sup>. Conversely, in suspected cases, the sonographic findings may definitely establish the pregnancy to be intrauterine rather than extrauterine<sup>7</sup>. Only case one was diagnosed before laparotomy, by clinical signs and symptoms and by a high index of suspicion of the examining physicians.

## Summary

In analysis of these three cases, several important points are brought out in the diagnosis of abdominal pregnancy. Abdominal pain and tenderness are usually present. Anterior displacement of the cervix seems to be a consistent physical finding. Radiographic examination may help if the classic signs are present, however, absence of these signs may be misleading. In the future, ultrasonography may prove to be a more valuable diagnostic tool in establishing the diagnosis of advanced abdominal pregnancy. Laparotomy is indicated when the diagnosis is established or if acute abdominal symptoms persist. The major pitfall, however, is probably the physicians's failure to keep the diagnosis of abdominal pregnancy in mind when evaluating a pregnant patient.



## References

1. Bobrow L, Bell H: Ectopic pregnancy. *Obstet Gynecol* 20:500, 1962.
2. Crawford JD, Ward JV: Advanced abdominal pregnancy. *Obstet Gynecol* 10:549, 1957.
3. King G: Advanced extrauterine pregnancy. *Am J Obstet Gynecol* 67:712, 1965.
4. Beacham W, Herquist W, Beacham D, Webster H: Abdominal pregnancy at Charity Hospital in New Orleans. *Am J Obstet Gynecol* 84:1257, 1962.
5. Cross JB, Lester W, McCain J: The diagnosis and management of abdominal pregnancy. *Am J Obstet Gynecol* 62:303, 1951.
6. Goldberg B: *Diagnostic Uses of Ultrasound*. New York, Grune and Stratton, 1975, 383.
7. Pritchard J, MacDonald P: *Williams Obstetrics*, 15th edition. New York, Appleton-Century-Crofts, 1976, p. 447.

65 Bergen Street, Newark

## AMA Study of Jail Inmate Health

Inmates in the nation's jails exhibit an alarming incidence of communicable diseases, according to an inmate patient profile completed by the American Medical Association.

Examination of 641 prisoners in the AMA's jail health care project revealed:

- 12.9 percent had positive test results for tuberculosis.
- 5.9 percent had positive results for syphilis.
- 30 percent had results indicative of liver malfunction, pointing to the possibility of hepatitis.

This high incidence of disease is especially disturbing because of the overcrowding common to U.S. jails. For example, in Cook County (Illinois) jail, an undetected TB victim was introduced recently into a crowded tier of prisoners. Upon discovery, TB skin tests were given to 107 inmates who had been in close proximity to him. Twenty-three percent showed positive reactions to the test. Since many inmates are released within a short time of apprehension, their exposure to disease endangers the general population.

The inmate patient profile, which defines the project for the first time, is an essential part of the AMA program to upgrade the medical care provided in American jails.

Because of insufficient medical care which most inmates have during their lives, 15 percent of those surveyed never had a physical examination, 16 percent had never been to a dentist, and 26 percent had never had their eyes ex-

amined. The AMA data show that 90 percent of the inmates surveyed had at least one medical complaint and in 60.9 percent of those cases, recommendations were made by the examining health professional that follow-up care was necessary.

The need for the AMA project has been underscored by the number of lawsuits by inmates which cite the lack of medical care as evidence of cruel and inhuman punishment. Less than 50 percent of the jails originally surveyed by the AMA in 1972 provided a regular sick call and only 17 percent held sick call on a daily basis. Of those jails surveyed, 27 percent had no emergency equipment at all, and 6 percent did not even have a first-aid kit.

The legal need for upgrading the nation's jails has been spelled out by three booklets produced by the AMA jail project. One, *Constitutional Issues of the Prisoners' Right to Health Care*, documents the constitutional right of a prisoner to adequate medical treatment. Another, *Legal Obligations to the Pre-Trial Detainee*, explores the rights of pre-trial detainees. A third, *Allied Health Personnel in Jails*, reviews the involvement of non-medical jail personnel in the delivery of medical care.

The need for improvement of medical care, says AMA jail project director Joseph Rowan, goes beyond the legal niceties. "When a society removes the right of a person to be self-sufficient, then it must provide him or her with the basics of life."

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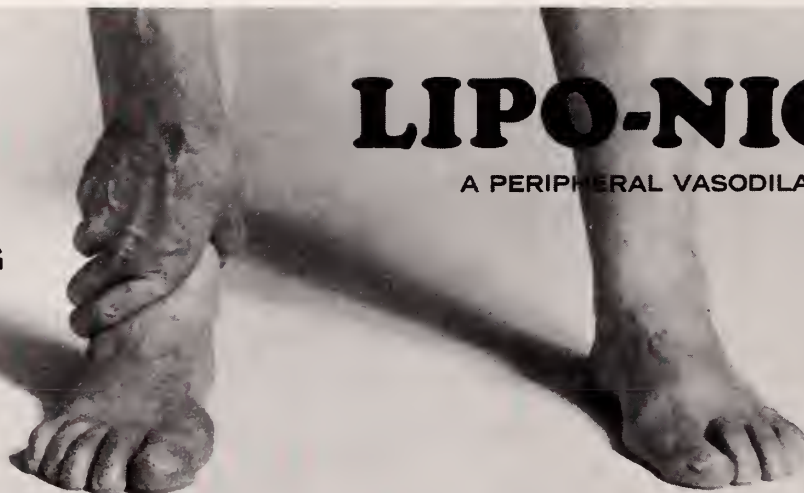


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*The current methods for the topical therapy of acne vulgaris juvenilis are reviewed and criticized. New data on the pathophysiologic function of the sebaceous gland are presented. A plea is made for no topical therapy for this common, self-limited disease.*

### Acne

Arlington Bensel, M.D., Point Pleasant

The routine dermatologic care offered most patients with acne vulgaris juvenilis is not only ineffective and archaic but also protracts the course of a self-limited disease. In the United States and in most foreign countries, the management of this most common cutaneous disease rests primarily with the pharmaceutical industries and the unconscionable advertising of the mass communication media. A vast array of topical preparations are advertised and the merits of these products are beamed at our young adults with brazen authority. The benefits of clinical studies are generally lacking. All of this is done to treat a self-limited disease. Is this not unconscionable? The shelves of our pharmacies are stuffed with topical preparations advertised for the management of acne. Our young adults are urged to wash with this, abrade with this one, soak up the oil with this, use this machine to scrub, this cream to give you the perfect skin, and so on . . . In no instance, however, is the effectiveness of any of these products demonstrated. Home ultraviolet lights, facial saunas, and abrasive preparations are irritating. And yet, utilizing the media, "Rock" programs on radio and TV, and teenage magazines, Madison Avenue continues to beam this propaganda at our young people.

This discussion is limited to acne vulgaris juvenilis, acne excoriée des jeunes filles, and acne cosmetica, hereafter lumped together and referred to as AVJ. It does not encompass the varieties of acne characterized by severe cystic or conglobated lesions, the varieties associated with bacterial infection, industrial contaminants, systemic medication, glandular abnormalities, immunological aberrations, emotional, genetic, or systemic disease. However,

the topical management of these more complicated varieties of acne, as will be presented, is essentially the same as for AVJ. The medical management of all varieties will be discussed in the light of more recent knowledge.

In dermatology we deal with the basic condition, but sometimes with a superimposed dermatitis resulting from previous treatment as well. This therapeutic aggravation is readily recognized by the experienced clinician. It has been said that therapeutic agents have necessitated more visits to the dermatologist than any single skin disease.<sup>1,2</sup> As Duma has stressed in an editorial,<sup>3</sup> the dictum attributed to Hippocrates: "Primum non nocere"—first of all do no harm—is basic in therapeutics. With the management of AVJ, however, this factor is often ignored.

A careful history of past routine care and self-medication usually shows an astounding assortment of preparations used. Direct questioning reveals periods of time spent examining the lesions with a mirror, squeezing, picking, rubbing, touching, and excoriating the involved areas. Further questioning reveals washing with many types of soaps and detergents, some with abrasive materials added. Lotions, creams, emollients, moisturizers, and make-up are applied. Professionally, vitamin-A acid or antibiotic topical preparations are applied. Cysts are injected with corticosteroids; carbon dioxide slush is scrubbed on the face; phenol peeling or dermabrasion is advised and the patient is told that these procedures will irritate but, after several weeks, improvement may be noted. All these preparations and procedures produce rather dubious lasting benefit.

## A Benign, Self-Limited Disease

AVJ is a benign, self-limited disease. In the United States it is the most common cutaneous disease. With some individuals it is disabling. It produces great concern, self-consciousness, embarrassment, and social withdrawal. When severe, AVJ is reason for rejection by the service academies and armed forces. When progressive, the scars resulting from the cystic, conglobated and keloidal varieties are distressing to behold. The expense involved in the overall management of AVJ is inestimable. It is about time that universal, rational, effective management be established.

## Pathophysiology of Acne

AVJ is a polymorphous disease characterized by an improperly functioning pilo-sebaceous apparatus with resultant follicular plugging, immature hair formation, localized inflammatory reaction, foreign body granulomas, and secondary bacterial invasion. Acne is a disease of the sebaceous glands responding to the androgens of puberty.<sup>5</sup> Strauss and Pochi have pointed out that androgen production is essential for the metabolism of sebum.<sup>6</sup> Kligman, Wheatley, and Mills have carried this a step further stating that with no androgen production there is no sebum, no comedone formation, and no acne.<sup>7</sup> Contrarywise, Cunliffe and Shuster have demonstrated that the greater the production of sebum the more the acne.<sup>8</sup> Knox and Owens have recorded that anovulatory females and castrated males are without acne.<sup>9</sup>

Rothman has documented, with the help of many notable contributors, the physiology, anatomy and biochemistry of the sebaceous gland.<sup>10</sup> More important here is the observation that degreasing the surface lipids will increase the amount of sebum that is excreted on the surface. The mechanism is not understood thoroughly, but either stimulation of the glandular function is initiated through mechanical irritation or the viscosity of the sebaceous aggregate is lowered and the oily material flows freely. The end result, however, is that washing will increase sebum production approximately four times. Further, it is known with a nursing mother that mere mechanical stimulation of

the nipple will produce milk. Embryologically, the primary germ of the sebaceous gland is related to the breast glandular tissue. It is plausible that stimulation of the skin will increase glandular function of the sebaceous apparatus. It is generally accepted therefore, and well recorded, that acne is a physiologic process occurring at puberty, the result of androgen metabolism from functioning ovaries and testes. Pillsbury has written about the explosive variety of acne, so called "tropical acne," that occurs under conditions of prolonged humidity and heat.<sup>11</sup> It has been recorded by the author that gentle, topical therapy and avoidance of external irritation will shorten the treatment period with many patients with AVJ.<sup>12</sup>

It has been shown, and photographic evidence is presented here, that simple hydration of the stratum corneum will occlude the follicular openings in AVJ.<sup>13</sup> Close visualization of the surface epidermis reveals the plugged and dilated follicular openings in the usual patient with AVJ. (Figures 1, 3, and 5) Constriction and occlusion of these follicular openings can be produced by hydration of the stratum corneum. This is demonstrated experimentally by the simple application of a compress of water for ten to twenty minutes. Identical factor close photography of the surface epidermis after the compress and comparison of the follicular openings demonstrates this constriction and occlusion. (Figures 2, 4, and 6) This swelling and resultant occlusion of the follicular openings may be a significant factor in the pathogenesis of the comedo. To be demonstrated adequately, the skin should be dry for several hours prior to the application of the compress.

The primary goal in acne therapy is to keep the follicular ducts open. When the follicular opening is blocked, the sloughing cells of the follicular epithelium are retained within the duct. The anaerobic diphtheroid, *Corynebacterium acnes*, and the sebum from the sebaceous gland also are present. Normally these products are excreted on the skin surface and act as an emollient, enhancing pliability, producing smoothness and maintaining a normal moisture content of the stratum corneum.



Figure 1 — Acne vulgaris juvenilis, chin area — before compress.



Figure 2 — AVJ after 15 minutes tap water compress. Note occlusion of follicular openings.



Figure 3 — AVJ — Forehead area, before compress.



Figure 4 — AVJ — Same area as Figure 3, twenty minutes after tap water compress. Note follicular occlusion.

Blockage of the follicular openings by any cause leads to what has been called "retention hyperkeratosis." The cellular debris, sebum and bacteria react through an enzyme (lipase) to produce hydrolysis of the triglycerides to free fatty acids and glycerol.<sup>14,15</sup> The irritating fatty acids lead to basophylic degeneration and atrophy of the epidermis in the infundibular portion of the follicle. In addition, clumps of immature hairs are often present in the sebaceous aggregate. These also may act as foreign bodies and initiate inflammation. The follicular wall becomes thin, the inflammatory infiltrate appears and a foreign body granuloma with giant cells appears in the upper corium surrounding the follicular ducts. This is the beginning of the inflammatory aspects of acne. With the dissolution of the follicular wall, papules, pustules, and cysts appear. Eventual

rupture or absorption of the lesion occurs, with or without scar formation. With hydration and swelling of the stratum corneum, the functionally normal but blocked sebaceous follicle gives further credence to the formation of "retention hyperkeratosis" in the infundibular portion of the sebaceous duct. When the sebaceous material and cellular debris become stagnant and solidified in the follicular duct, because the follicular opening is "bunged up," a comedo is formed. It naturally follows that any procedure that produces hydration or edema of the stratum corneum will plug the follicular openings. It is suggested that the water retention, associated with premenstrual flare acne, may be related to increased hydration of the stratum corneum with resultant occlusion of the follicular openings.





Figure 5—AVJ—cheek area.



Figure 6—AVJ—same area as Figure 5, after twenty minute tap water compress. Note follicular occlusion.

### Topical Neglect

The primary reason for this presentation is to demonstrate the importance of topical neglect. For the past several years the author has practiced what he calls "absolute topical neglect" in the management of AVJ with gratifying clinical results. Absolute topical neglect is just that. No topical preparations are allowed; there is no washing, and the skin is kept as dry as possible. For the females, a minimum of make-up is allowed, but involution is quicker without it. The patients are instructed to leave the skin alone completely—no washing, wetting, picking, squeezing, manipulation or application of any sort. In practice this is a difficult thing to do. It entails cooperation on the part of the patient, breaking time-honored habits and changing advice that is offered freely by pharmaceutical companies, cosmeticians, soap manufacturers, and many dermatologists. For the habitual manipulator, the individual is encouraged and instructed to leave the skin alone completely. This is usually successful but, if persistent, it may be symptomatic of deep psychotic behavior and require psychiatric help.

### Treatment of Acne

The *systemic medical management* of acne vulgaris is individualized depending on age, severity, grade, infection, emotional state, heredity, endocrine imbalance, and vanity.

Systemic antibiotics are indicated in the pustular, cystic, and conglobated varieties of acne. In adequate dose tetracycline is beneficial, not only for its antimicrobial effect but also it is reported to reduce the concentration of free fatty acids in the sebum.<sup>16</sup> Tetracyclines should be avoided in pregnancy because of irreversible staining of deciduous teeth and localization in mineralizing tissues of the fetus.<sup>17</sup> There is also evidence that skeletal growth may be inhibited.<sup>18</sup> Vaginal moniliasis and photosensitivity may be other complications of tetracycline therapy. Broad spectrum antibiotics, such as minocycline, may be substituted.

*Corticosteroid therapy* in inflammatory acne may be very beneficial, especially in the sensitive or allergic individual. A paradox exists here in that the so-called "steroid acne" may

develop with protracted corticosteroid therapy. However, when acne is severe, and has not responded to other modalities, short courses of parenteral corticosteroids may be justified.

*Hormone therapy* in the form of cyclic administration of the contraceptive pill is beneficial in the mature female to counteract the androgen stimulus of the sebaceous gland. Torre and Klumpp have found that rather high doses of estrogen are required to show significant improvement.<sup>19</sup> The use of estrogen-progestin drugs is advocated by Strauss and Pochi<sup>20</sup>, but the time to produce significant improvement may be up to three months. Estrogen preparations are contraindicated in the male because of feminizing effects.

There has been an upsurge of acne in adult females the past few years that is associated with the discontinuing of the contraceptive pill. The estrogen component of the contraceptive pill is responsible for suppression of the sebaceous gland excretion. These patients usually are upset because of their appearance and almost universally resort to many topical applications. This "contraceptive pill cessation acne" responds to no topical therapy and time. On occasion it may be advisable to resume the contraceptive pill in selected cases.

*Dietary management* of acne is suspect. It is important that the diet be adequate and the meals regular, but the avoidance of nuts, chocolate and fatty foods is not as important now as it was thought to be.

*Emotional support* is an important facet in the systemic management of acne. The withdrawn, sullen, sometime aggressive, depressed, and angry individual is in great need of supportive psychotherapy. This can be done by any physician by getting to know the patient and offering encouragement and understanding. On occasion minimal doses of psychotropic medication (Librium®, Valium®, Stelazine®) may be helpful. Acne, of course, is most common with the beginning of puberty and sexual maturation. There may be doubts and guilt about sexual function and, when rapport is established, these

precursors of anxiety may be discussed and alleviated.

For many years, and not uncommon today, the erroneous belief that masturbation will cause acne has been held. In 1871, and recorded by an Act of Congress and the Office of the Librarian of Congress in Washington, D.C., Dr. R. J. Jourdain of Boston published a booklet entitled "Nervous Debility and Physical Exhaustion." Most of this booklet of 181 pages is about the evils of self-pollution, onanism, or masturbation. I quote briefly: "Pimples not only appear in the face but also the function of the intestines are sometimes quite disordered. The organs of generation participate in misery and many are incapable of erection. Distraction, or absence of mind, render judgment unfit for any operation. Alopecia, consumption, and insanity, then, may be regarded as the sad and not infrequent termination of these cases."<sup>21</sup> Unfortunately, some of these false ideas persist. Education of the young people that masturbation is harmless will relieve some emotional stress. A frank discussion, with adequate rapport, about intimate behavior will alleviate many adolescent emotional problems.

### Other Modalities

Superficial *x-ray therapy* has been used for years for acne vulgaris, and its beneficial effect is well documented, however, its long-time effects are suspect and it is not advocated. Many other modalities and preparations have been advocated in the therapy of acne vulgaris such as: oral vitamin A, vitamin E, Staphylococcus vaccine, insulin, gamma globulin, crude liver, and so on but their effectiveness is inconclusive.

### Summary

A revolutionary approach to the topical management of AVJ is presented. The widespread use and advertising of the many topical preparations utilized for the treatment of AVJ are criticized. The physiology of sebaceous gland activity is reviewed, and new information on follicular plugging and comedo pathogenesis is presented. Absolute topical neglect is advocated for the external management of AVJ. Systemic management is discussed.

## Bibliography

1. Lane C Guy: Therapeutic dermatitis. *N Engl J Med* 246:77, 1952.
2. Miller HE, Ayres S Jr, Alderson HE: Overtreatment in dermatology. *Calif West Med* 227:293, 1942.
3. Duma Richard J: Editorial. *N Engl J Med* 258:22, 1971.
4. Hippocrates with English translation by W.H.S. Jones. Vol. 1, Cambridge Univ. Press, 1923, p. 165.
5. Shelly WB: *Acne, Consultation in Dermatology*. Philadelphia, Saunders, 1972.
6. Strauss JS, Pochi P: Recent advances in androgen metabolism and their relation to the skin. *Arch Derm* 100:621-636, 1969.
7. Kligman AM, Wheatley VR, Mills OH: Comedogenicity of human sebum. *Arch Derm* 102:267-275, 1970.
8. Cunliffe WJ, Shuster S: Pathogenesis of acne. *Lancet* 1:685-689, 1968.
9. Knox JM, Owens DW: The role of hormones in acne. *Rocky Mount Med J* 63:10:75-78, 1966.
10. Rothman S: *The Physiology and Biochemistry of the Skin*. Chicago, University of Chicago Press, 1975.
11. Pillsbury DM: *A Manual of Dermatology*. Philadelphia, Saunders, 1971.
12. Bense Arlington: Acne. *Cutis* 16:32-34, 1975.
13. Bense Arlington: The pathogenesis of the comedo. *Cutis* 18:68-69, 1976.
14. Reisner, RM, Silver DZ, Puhvel M, Sternberg TH: Lipolytic activity of corynebacterium acnes. *J Invest Derm* 51:190-196, 1968.
15. Kellum RE, Strangfeld K, Ray LF: Acne vulgaris: Studies in pathogenesis: Triglyceride hydrolysis by corynebacterium acnes in vitro. *Arch Derm* 101:41-47, 1970.
16. Freinkel RK, Strauss JS, Yip SY, Pochi PE: Effect of tetracycline on the composition of sebum in acne vulgaris. *N Engl J Med* 273:850-854, 1965.
17. Kline AH, Blattner RJ, Lunin M: Transplacental effect of tetracyclines on teeth. *JAMA* 188:178-180, 1964.
18. Cohlan SQ, Bevelander G, Tiamsic T: Growth inhibition of prematures receiving tetracycline: A clinical and laboratory investigation of tetracycline-induced bone fluorescence. *Am J Dis Child* 105:453-461, 1963.
19. Torre D, Klumpp MM: Cyclic estrogenic hormone therapy of acne vulgaris. *JAMA* 164:1447-1450, 1957.
20. Strauss JS, Pochi PE: Effect of cyclic progestin-estrogen therapy on sebum and acne in women. *JAMA*: 190:815-819, 1964.
21. Jourdain RJ: Nervous debility and physical exhaustion: Washington, Recorded by U.S. Congress and Library of Congress, 1871.

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## National Cancer Institute Seeks Referrals

The cooperation of physicians is requested by the National Cancer Institute for the referral of patients for study of the following diseases:

**Male breast cancer**—patients in all stages of the disease are acceptable if they are ambulatory, over 65 years of age, and otherwise in good health. The study will involve evaluations of chemotherapy and hormone therapy.

**Breast cancer**—patients with disseminated breast cancer will be considered if they are less than 65 years of age and have received no prior hormone therapy or chemotherapy and have no

complicating medical disease.

Please communicate with Attending Physician, Medicine Branch, National Cancer Institute, Clinical Center—Room 12N-226, National Institute of Health, Bethesda, Maryland 20014, telephone (301) 496-4916.

**Oat Cell Carcinoma of the Lung**—please communicate with Harmar D. Brereton, M.D., National Cancer Institute, Clinical Center—Room B3B-38, National Institutes of Health, Bethesda, Maryland 20014, telephone (301) 496-5457.



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## TRUMAN CLOSES ED NATIONS CONFERENCE TH PLEA TO TRANSLATE HARTER INTO DEEDS

### NEW WORLD HOPE

President Hails 'Great  
Instrument of Peace,'  
Insists It Be Used

### HISTORIC LANDMARK

Meeting Gives Standing  
Ovation as Executive  
Pictures Peace Gain

"If we fail to use it," he declared  
to the solemn final meeting of the  
delegates, 'we shall betray all of  
those who have died in order that  
we might meet here in freedom and  
safety to create it.'

"If we seek to use it selfishly—for  
the advantage of any one nation or  
any small group of nations—we  
shall be equally guilty of that betrayal."

#### Fervent Interpolation

The President, speaking in the  
auditorium of the War Memorial  
Opera House, built in memory of  
sons of the Golden Gate city who  
gave their lives in the first World  
War, in which he himself served,  
seemed to give unconscious expres-  
sion to the solemn feeling of the  
occasion when, at the outset of his  
speech, he interpolated the words,  
half a hope, half a prayer:

"Oh, what a great day this can  
be in history!"

Just before the plenary session  
the President accompanied the

## Social Security Bill Is Signed; Gives Pensions to Aged, Job

Roosevelt Approves Message Intended to Benefit 30,000  
Persons When States Adopt Cooperating Laws—He C  
the Measure 'Cornerstone' of His Economic Program

## SENATE APPROVES 18-YEAR OLD VOTE IN ALL ELECTIONS

Amendment to Constitution  
is Sent to House, Where  
Passage is Expected

WASHINGTON, March 10,  
1971—The Senate approved  
today, 94 to 0, and sent to

WASHINGTON, Aug. 14  
The Social Security Bill, pr  
a broad program of unempl  
insurance and old age p  
and counted upon to bene  
20,000,000 persons, became  
day when it was signed by  
dent Roosevelt in the pres  
those chiefly responsible f  
ting it through Congress.

Mr. Roosevelt called the r  
"the cornerstone in a st  
which is being 1971 but  
me's comple  
ring to

# SIGN the Draft Ends No

WASHINGTON, Jan. 27,  
1973—"With the signing of  
the peace agreement in  
Paris today, and after re-  
ceiving a report from the  
Secretary of the Army that



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# PATIENT PACKAGE INSERTS: A CONCEPT WHOSE TIME HAS COME?

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*The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely-prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.*

*The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.*

## **The Advantages**

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

Every doctor has had patients who fail to finish antibiotic regimens because they feel better. Some patients assume that if one tranquilizer or analgesic is good, two may be twice as good. Still others fail to report dizziness while on antihypertensive therapy—and so on.

Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

## **The Disadvantages**

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information

is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

## **The Solution**

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.

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### British National Health Service in 1977 — Part II

#### General Practice

The general practitioner is considered the bed-rock foundation of health care in the U.K., but NHS has seen a definite decline in the number of physicians entering general practice. The original plan was that family doctors would work in groups in newly constructed health centers, which were to be well equipped and staffed with nurses, office assistants, technicians, and so on. This has not happened because of the shortage of money. A majority of G.P.'s practice in their own homes, or in small, converted bungalows or other buildings. Equipment and furnishings are sparse. Applications by existing groups of general practitioners for a health center must be approved by the AHA and this may take years.

The G.P.'s in Great Britain comprise about half of the country's qualified medical work force, manage about 90 percent of all illnesses but receive only eight percent of the NHS budget.

The daily routine of the generalists is to have one or two "surgeries" (periods of office hours) during each of which 25 or so patients are seen. House calls are made daily — anywhere from six to forty visits (the latter during a measles epidemic). Observation on one general practice office disclosed that the patients appear in the doctor's waiting room on the day of the appointment and "take a number." When his number appears on a board in the waiting area, the patient goes back to the combined consultation-examining room. The care is primarily crisis-care, symptomatic treatment or referral, and issuance of prescriptions. A variety of government certificates (confinement, sick benefits, and so on) take up a good deal of time. History and physical examinations at office visits are meager. The more "complex" patients (diabetes, coronary heart disease, and so on) are managed by the consultants, while the G.P. mainly completes prescriptions and treats minor acute illnesses or stable chronic diseases. Pelvic examinations and rectal examinations

are done rarely in the busy general practice, while complete physical examinations are almost unheard of.

The G.P.'s are perfectly capable of doing these procedures and are aware of their value, but there is neither time nor compensation for them. Many routine office visits are handled entirely by the office nurse, while most of the home health care along with a modicum of health education is handled by district nurses. These ladies (the one in the office we visited was affectionately called "Flossie" — short for Florence Nightingale) made as many as 40 home visits daily, giving injections, changing dressings, dispensing nutrition advice, giving terminal cancer care, and so on. The district nurses work closely with the G.P.'s and their practice patient load.

The medical records in the doctor's office are uniform as developed by the DHSS. They consist of a Summary of Treatment Card (4 $\frac{3}{8}$ " x 7") on which progress notes are made at each visit. The notes are sparse, so that perusal of several envelopes of such records for a number of patients gave this writer no idea of the patients' health problems, status, history, or treatment. No data base was present; only brief office visit notes were handwritten. These records pass from G.P. to G.P., by way of the various health authorities, when a patient makes a geographic move, but there is usually a lag of several months before the new physician receives the patient's record. A Medical Records Officer in a British text summed up the situation as follows:

"What the general practitioner does and why he does it is known to him at the time. In some cases it is recorded in its bare essentials. Most of the record is committed to that fading document, the human memory. Systematic recording in the absence of a secretary or a mechanical aid, and with an average of only a few minutes of consultation time, is impracticable.

"The small size of the envelope (7" x 4 $\frac{3}{8}$ ") is the main problem. Handwriting becomes cramped and illegible and the conscientious record-keeper finds himself trying to

force fat packets of dog-eared paper into files already bursting with irretrievable information."

A good deal of the G.P.'s time is spent making referral phone calls or dictating referral letters to arrange office appointments for his patients with consultants. A review of the area list of specialists revealed delays of weeks to months to obtain such an appointment. For example, the appointment schedule for the area cardiology consultant was filled for 18 weeks. Delays of two to eight weeks for other specialists were characteristic. Where urgency was a problem, the G.P.'s ability to convince the consultant of that fact sometimes produced an earlier appointment.

The only apparent advantages of the Health Center was its modern design and construction, the pleasant internal and external appearance, the modern furnishings, and the very ample space. The equipment present was of recent vintage, but the general operation of the practice is exactly the same as that in the home or bungalow office. There are no electrocardiographs, x-ray machines, or laboratory facilities on the premises. Patients must travel about ten miles to the hospital or consultant's office for these services. EKG's are occasionally done at home by the cardiologist in an emergency, but he must be convinced of the necessity.

In talking to G.P.'s in the small private office, and those in a new Health Center, the former were envious. Despite the desire to work in a Health Center, the G.P.'s expressed a major cause for anxiety: the government is their landlord, their practice manager, and their paymaster.

### Voluntary Health Agencies

It was a surprise to learn that Great Britain has many voluntary health agencies, e.g., the British Diabetic Association, the British Cancer Council, the Malcolm Sargent Cancer Fund for Children, and some eleven other cancer societies and numbers of agencies devoted to other diseases and health problems. One would suspect that a "social democracy" which has a virtual monopoly on health care would not require voluntary health agencies, but they exist — with great difficulty.

The British Diabetic Association (BDA) is typical. It was founded in 1934 through the efforts of Dr. R. D. Lawrence and a patient of his, H. G. Wells; H. M. Queen Elizabeth II is the patron of the Association. The 1977 membership of this organization is 53,000, with 500 doctors and scientists. Despite the fact that it receives no government or other grants, the 1976 income of the BDA was £ 664,781 (\$1,189,958), which came from donations, legacies, subscriptions, dividends, and sales. Mainly, the functions of this organization are to provide advice for diabetics, produce a newspaper and many educational publications, plead the case of the elderly and other patients with financial difficulties with government bodies, organize conferences for professional people, provide funds for research groups and individuals, run holiday camps for diabetic children, and "campaign incessantly to wipe out prejudice and ignorance about diabetes." Administrative costs were only 5.8 percent; 25 percent of the income was distributed as research grants. The remainder went for direct services, health education, children's camp expenses, and medical and scientific costs.

Like all other voluntary health agencies in the United Kingdom, the BDA is the victim of its nation's laws of charity. The agencies are not permitted to "advertise," i.e., to solicit contributions in the press, on the radio or television, or by public billboards. Furthermore, charitable contributions by individuals or corporations are not deductible from the income tax. The only "benefit" is the "Deed of Covenant," which is an agreement to contribute a certain amount annually to the charity for seven years. If the donor pays income tax during that period, the registered charity may recover from the Inland Revenue the tax which the donor paid on that money he subscribed. Thus a £ 25 (\$45) contribution is worth £ 35 (\$63) to the charitable organization. This means a good deal to the recipient but there is no real incentive to contribute funds. The exception is the concert or other performance for charity. A remarkable concert at the Royal Opera House, Covent Gardens, was possible because Sir George Solti, an assistant conductor, and ten of the world's great singers gave their services



without charge for the benefit of the Malcolm Sargent Cancer Fund for Children. The cost of the tickets was not tax deductible but the cancer society reaped the financial benefit.

Are the voluntary health agencies important? Dr. B. D. Young, BDA Vice-President said:

"When the National Health Service came into being it seemed that the need for voluntary bodies might diminish. The contrary is true, and at no time since the creation of the welfare state are the efforts of voluntary associations more needed than the present."

### Private Practice

Private practice, which is almost nonexistent in the United Kingdom, is under great political pressure and may be eliminated completely in the near future. Many NHS hospitals retain a few private beds to which specialists may admit patients who pay a daily charge of up to \$100. Those consultants who provide private hospital care must sacrifice about 10 percent of their government salary for that privilege. Private office care is also difficult because those patients who are treated privately by consultants cannot obtain prescription drugs under the NHS from the specialist. The cost of drugs must be borne by the patient, who may find this expense prohibitive, or the patient must ask a general practitioner to prescribe the drugs.

One form of "private practice" by the generalist is the fee-for-service vasectomy performed in the doctor's office or Health Center.

There has been a move on the part of many companies to provide an insurance benefit for their senior employees by paying the costs of private care. The desperate attempt of British consultants to embrace private practice "as the last remnant of their personal and professional freedom" is being adamantly opposed by the ruling Labour government which is determined to eliminate all private beds in hospitals. The Labour Party "comes out strongly and predictably against any moves to levy more charges on patients for particular services or hospital beds. It opposes any move towards medical insurance schemes..."

Although about a third of the specialists receive extra salary for distinction awards, less than

half of all consultants do private practice in addition to their National Health Service stint. A major source of irritation to the consultants is the fact that the pay of junior hospital doctors, who get paid extra sums for working overtime in the hospital, often exceeds the annual salary of consultants and senior hospital physicians.

### Nursing Care

The mainstay of community health appears to be the district visitor, the equivalent of our visiting or home care nurse. One such nurse who was interviewed stated that she makes 40 house calls daily to inject insulin, antibiotics, or analgesics, administer care to terminal cancer patients, bedside nursing for stroke victims, and so on. She drives her own car and is reimbursed for gasoline only. Twelve-hour days are the routine because there are too few nurses. She stated that there are many unemployed nurses available, but the shortage of funds precludes their working. The shortage of nurses in hospitals also was apparent. I observed only two nurses on duty in a four-bed intensive care unit in Guy's Hospital.

The shortage of nurses was described in a *Sunday Telegraph* article about a 592-bed district general hospital in London in the words of a ward sister:

"I am appalled. We're badly off for equipment, badly off for staff, badly off for nurses. This is a very heavy ward and I put in 20 hours a week overtime just to keep things going."

Two years earlier that hospital had an economy freeze imposed. "New furniture and equipment weren't bought, recruiting was stopped, morale fell." The writer went on to say:

"It's (the hospital) well supplied with good doctors, because it has certain specialisations and teaching hospital connections which attract them. But while its total of 541 nurses sounds a lot (and is certainly an improvement on a year ago), it hardly guarantees the minimum cover of three trained staff (plus students) per 24-hour general ward, and in an ideal world there would be four."

### Elective Hospital Admission

The plight of the patient who requires elective surgery or elective in-hospital medical treatment was dramatized during our visit by a 36-year-old mother of five. The lady "jumped a queue of 400 people waiting for surgery" when

she "walked into a hospital in Northampton, climbed into an empty bed and refused to move until doctors agreed to carry out surgery." She had been informed that the waiting period for a cholecystectomy would be twelve months, but from her hospital bed the patient said, "I am not going to move. The only way to get me out of here is in a wooden box." The story went on to describe her unemployed husband's angry statement as well:

"I was told by the authorities at Northampton General Hospital that my wife would be admitted immediately if we could pay for the operation to be done privately. I was told this would cost £ 39.50 a day and over a ten-day necessary stay, together with the consultant's fee, this would total £ 500."

The reaction of the community at large was expressed through the hospital switchboard which was swamped by abusive phone calls from many patients who had been awaiting hospital admission for many months.

### Podiatry

In the seaside village of 15,000 we visited, there was no podiatric service available, however, some foot treatments were provided in a distant

health center on a once-a-week basis. The national situation is apparently equally bleak according to a report of recent debate in Parliament: "Nine out of ten adults may have foot defects according to Health Minister Roland Moyle, who admitted that the NHS chiropody service was seriously undermanned." In a debate initiated by William Molloy (a Labour Party representative), the MP protested about the lack of a safeguard for protecting the public from "fake chiropodists." He said anyone, whatever his training, could call himself a chiropodist and treat patients privately. "Only recently the Commons passed legislation to ensure that only qualified blacksmiths could shoe horses. Anyone can pose as a chiropodist and treat the feet of human beings," said Mr. Molloy. He admitted that a tremendous leeway had to be made good before there could be a satisfactory chiropody service within the NHS. One estimate indicated that the work force would have to be doubled even to meet the needs of priority groups." A. Krosnick, M.D.

The concluding segment of the commentary on the BNHS will appear in the November issue.

### Wanted: Referrals of Soft Tissue Sarcomas

The cooperation of physicians is requested in the referral of patients with metastatic soft tissue sarcoma for drug therapy trials conducted by the National Cancer Institute's Clinical Pharmacology and Medical Branch at the Clinical Center, National Institutes of Health, Bethesda, Maryland. Patients with metastatic disease or multiple recurrences are acceptable if they are ambulatory, under 55 years of age, have no known heart disease, and are in otherwise good health. Patients who have received prior adriamycin chemotherapy or mediastinal radiotherapy are ineligible, but radiation therapy to other sites would not disqualify them. Those interested in further details and in having their patients considered for admission may write to Dr. Charles E. Myers, National Cancer Institute, Clinical Pharmacology Branch, Building 10—Room 6N119, Bethesda, Md. 20014 (301) 496-6565.

# NEW JERSEY DOCTORS' NOTEBOOK

## Report from the Foundation

**Daniel J. O'Regan, M.D., Medical Director**

In August, the *Newark Star Ledger* reported that: "U.S. Awards \$390,000 to Mor'is HMO." This refers to a health maintenance organization known as CoMed, Inc., which has been hard at work for a long time to achieve its goal. That goal is to provide prepaid health care to subscribers in return for an annual premium. CoMed's service area will include all of Morris County, and portions of Passaic and Somerset. According to the article, the program will be capable of serving more than a half million people.

The Federal Register, August 19, 1977, announced that new grant applications to expand the geographic distribution of health maintenance organizations will now be considered. This opens a new round of Federal financial assistance for the development and initial operation of Health Maintenance Organizations.

Mr. Frank Seubold, Director of HMO operations at HEW, says that there will be a "strong push" for the expansion of HMO activity. Under-Secretary of DHEW Hale Champion has expressed the same ideas. The Ford Motor Company is talking to representatives of the Kaiser plan about setting up a prepaid plan in the Dearborn, Michigan area. You may have read that Reynolds tobacco company has set up its own center for providing care to its employees and their families. Reynolds did not decide to get out of the cigarette business, which might do more for the public's health, but that's another story.

Hospitals which do business with HMOs may be exempt from the 9 percent "cap" proposed by Secretary Califano.

The above items are intended to direct your attention again to the growing concept of prepaid health care. NJFHCE, as you know, is

interested in the Individual Practice Association—or IPA—form of delivery. The private sector (you and I) should have some concern with cost-effectiveness, but our main concern is the quality of care. As someone said, if you can't deliver quality, there's not much sense in trying to conserve costs. The future growth in prepaid health care well may be more in the IPA mode than in the closed-panel HMO. We are continuing to suggest that our colleagues keep these trends in mind. There is much more interest around the State than there was six months ago. It started in the West, but it's right in your back yard.

## CMDNJ Notes

**Stanley S. Bergen, Jr., M.D.**  
**President, CMDNJ**

As you read this, students still are returning to their studies at the College's six schools. Although final enrollment figures were not available at press time, CMDNJ welcomed its largest student body ever when classes opened in September.

Part of the increase in enrollment is due to the opening of CMDNJ's new School of Osteopathic Medicine, where the first class of 24 students began studies. The first phase of CMDNJ-Rutgers Medical School's expansion of its third and fourth-year classes also swelled the rolls of returning students. This year, the Piscataway school was able to provide places for 72 students in its third-year class, compared to 56 in previous years.

At the CMDNJ—New Jersey Medical School, Newark, students are settling in at the laboratories and lecture halls of the new Medical Science Building. The long-awaited opening of the medical school took place officially last month at a campus-wide convocation. Dr. Lewis Thomas, president and executive director of the Sloan Kettering Memorial Hospital,



New York, served as keynote speaker at the dedication service.

Completion of the \$56-million facility is a milestone in CMDNJ's short history. With only the College Hospital still under construction and due for occupancy within the year, the College now can move out of the building phase and concentrate on the expansion of its teaching and service programs in health care and the life sciences.

## Therapeutic Drug Information Center\*

### 1. Please provide information concerning the drug interaction between alcohol and diazepam.

Interactions of central sedatives and alcohol are well known. In most of the cases there is an additive effect when the two are combined. Investigations in normal volunteers indicated that diazepam (Valium®) and ethanol in combination may have additive or synergistic detrimental effects on driving skills.<sup>1</sup>

Hayes, *et al.*<sup>2</sup> reported an interesting study in which ethanol was shown to enhance the oral absorption of diazepam. The study was conducted on seven normal volunteers. Each subject received diazepam on the first day in a dose of 0.07 mg/kg orally suspended in 30 ml of distilled water. On the second day subjects received diazepam suspended in a 50 percent v/v mixture of ethanol and water. Blood samples were collected for diazepam analysis at 30, 60, 90, 120, and 240 minutes after dosing each day. The results demonstrated that in addition to additive sedation, combined alcohol and diazepam ingestion resulted in higher plasma levels of diazepam than when diazepam was given alone. The

authors concluded that increased absorption of diazepam may also contribute to the potentiation of CNS sedative action.

Several letters to the editor have questioned the above study on the basis of faulty design, and the question of alcohol increasing the absorption of diazepam is unsettled.<sup>3,4</sup> In any case, however, there is at least additive CNS depressant effects when the two are combined.

### References

<sup>1</sup>Linnoila M, *et al*: Effects of diazepam and codeine, alone and in combination with alcohol, on simulated driving. *Clin Pharmacol & Therap* 15:368 (Apr. 1974).

<sup>2</sup>Hayes SL, *et al*: Ethanol and oral diazepam absorption. *N Engl J Med* 296:186 (Jan 27) 1977.

<sup>3</sup>Bernstein R, *et al*: Diazepam-ethanol interaction. *N Engl J Med* 296:1006 (Apr 28) 1977.

<sup>4</sup>Boden WE: Diazepam-ethanol interaction. *N Engl J Med* 296:1006 (Apr 28) 1977.

### 2. Please supply me with information on the use of cromolyn in ulcerative colitis.

The mainstay of drug therapy in the treatment of ulcerative colitis includes oral sulfasalazine (Azulfidine®) and/or steroids either given systemically or by retention enema. Cromolyn (Aarane®, Intal®), a poorly absorbed drug inhaled for the prophylaxis of chronic asthma, is being investigated by the oral and rectal routes for use in ulcerative colitis and related conditions.

Mani, *et al*<sup>1</sup> reported a double-blind placebo crossover controlled study on 12 out-patients with ulcerative colitis. The patients received identical tablets of either a placebo or the drug. The starting dose of cromolyn was 200 mg twice daily, and progressively increased to 500 mg four times a day at the end of four weeks. At the end of the six-month period, cromolyn treatment was found to be statistically better than placebo when measuring the patients' sense of well-being and by sigmoidoscopic and rectal biopsy appearances, but not in stool frequency or rectal bleeding.

Heatley and associates<sup>2</sup> conducted an eight-week randomized double-blind crossover trial on 26 patients with chronic proctitis. Two hundred mg of cromolyn in 40 ml of warm water was administered by enema twice daily plus 100 mg capsules orally twice daily. The treatment group was alternated with an identical placebo group. Results as determined by sigmoidoscopic examination, bowel frequency, blood loss, and patient general assessment revealed that 14 patients responded to cromolyn, 10 showed no change in either group, and 2 responded to placebo. Although there was no consistent change in blood eosinophil count associated with patient's clinical progress, the rectal biopsies demonstrated that responders to cromolyn had significantly more eosinophils than those who failed to respond.

Cella, *et al.*<sup>3</sup> also reported positive results to cromolyn treatment in selected cases of colitis. Heatley, *et al.*<sup>4</sup> measured immunoglobulin E in rectal mucosa of patients with proctitis. They suggested that an increase of IgE pro-

\*The Schwartz Inter-National Pharmaceutic and Therapeutic Drug Information Center of the Brooklyn College of Pharmacy, Long Island University, compiles the information contained in this column each month. The Center serves as a source of intelligence on therapeutic and pharmaceutic information not readily available to physicians, at no charge to them, and provides this information with minimal time involvement. It is staffed by trained pharmacists; Jack M. Rosenberg, Pharm. D., Associate Professor and Chairman, Division of Clinical Pharmacy, Brooklyn College of Pharmacy, is Director and Walter Modell, M.D., Emeritus Professor of Pharmacology at Cornell University Medical College, is pharmacologist consultant. The service is available Monday through Friday from 9 a.m. to 4:30 p.m.—telephone (212) 622-8989 or 303-2735. The following are questions and answers handled by the Center recently.

This month's column was prepared by J. M. Rosenberg, M.S., Pharm. D., M. K. Raina, M. Pharm., Ph.D., P. Sangkachand, B.S., Brooklyn College of Pharmacy, LIU.

ducing cells with an excess of eosinophils in rectal mucosa was associated with positive clinical response to cromolyn. This supports the theory of a hypersensitivity reaction in the pathogenesis of this condition. As in asthma the authors proposed that cromolyn inhibits the breakdown of mast cells which results from antigen reacting with cell bound antibody (IgE), which otherwise would cause the release of pharmacologically active substances which damage the local tissue.

In conclusion, the finding that cromolyn results in clinical improvement in certain patients with ulcerative colitis and proctitis is exciting both in the elucidation of the pathological mechanism of the disease as well as in the therapeutic aspects of its treatment. Whether cromolyn will be used alone or in combination with other drug therapies, and if it will be a mainline or secondary treatment has yet to be determined as does its most optimum dosage schedule and routes of administration.

#### References

- <sup>1</sup>Mani V, *et al*: Treatment of ulcerative colitis with oral disodium cromoglycate—A double-blind controlled trial. *Lancet* 1:439 (Feb 28) 1976.
- <sup>2</sup>Heatley RV, *et al*: Disodium cromoglycate in the treatment of chronic proctitis. *Gut* 16:559 (July) 1975.
- <sup>3</sup>Cella GD, *et al*: Ulcerative colitis and disodium cromoglycate. *Lancet* (May 22) 1976.
- <sup>4</sup>Heatley RV, *et al*: Immunoglobulin E in rectal mucosa of patients with proctitis. *Lancet*, 1:1010 (Nov 22) 1975.

#### 3. Please provide information concerning the treatment of tardive dyskinesia with papaverine.

Tardive dyskinesia is a late-appearing neurological disorder associated with antipsychotic drug use. An incidence as high as 20 percent has been reported in chronically institutionalized patients. The syndrome is characterized by involuntary movements consisting of sucking and smacking of lips, lateral jaw movements, and fly-catching dartings of the tongue. There may be choreiform and purposeless quick movements of the extremities. Symptoms may persist indefinitely after the discontinuation of the medications.

Until now no adequate therapy has been devised for this syndrome and the search for effective treatment continues to be a major therapeutic challenge. Antiparkinson drugs have proved ineffective. Antipsychotics, when given in high

doses may mask the symptoms but the dose of the offending drug should not be increased to produce this effect. Among the other therapeutic modalities, use of a sedative or an antianxiety agent may alleviate some of the motor symptoms.<sup>1</sup>

An interesting observation led to the use of papaverine in tardive dyskinesia. Duvoisin<sup>2</sup> reported a finding that papaverine antagonized the therapeutic effects of levodopa in a 71-year-old patient. This antagonism was attributed to the ability of papaverine to block dopamine receptors. Since the dopamine pathway presumably is implicated in dyskinetic movements, this may form the basis for the use of papaverine in tardive dyskinesia.

Gordos and Cole<sup>3</sup> administered papaverine in doses of 300 to 600 mg daily for three female in-patients, who showed moderately severe tardive dyskinesia. Weekly evaluation of various parameters in these patients showed an improvement in dyskinetic state without any side effects.

Gordos, *et al.*<sup>4</sup> conducted a study on nine hospitalized patients with moderate to severe tardive dyskinesia. Papaverine was administered orally, 300 mg twice daily, in sustained-release capsules (Pavabid®), and the treatment period varied from two to six weeks. The patients were rated weekly for ten weeks on various psychiatric scales. Results showed 20 to 25 percent improvement in oral dyskinesia, but only two of the nine patients showed clinical improvement in their movement disorders. No untoward effects were observed.

In conclusion, it appears that papaverine may have a limited use in the treatment of tardive dyskinesia. Since no effective treatment is known for this condition, any drug that is of even limited value is worthy of further evaluation.

#### References

- <sup>1</sup>Singh MM: Diazepam in the treatment of tardive dyskinesia—Preliminary observations. *Int Pharmacopsychiat* 11:232 (Nov) 1976.
- <sup>2</sup>Duvoisin RC: Antagonism of levodopa by papaverine. *JAMA* 231:845 (Feb 24) 1975.
- <sup>3</sup>Gordos G and Cole JO: Papaverine for tardive dyskinesia. *N Engl J Med* 292:1355 (June 19) 1975.
- <sup>4</sup>Gordos G, *et al*: An evaluation of papaverine in tardive dyskinesia. *Jour Clin Pharmacol* 16:304 (May-June) 1976.

## PATRONIZE OUR ADVERTISERS

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# The Society for the Relief of the Widows and Orphans of Medical Men of New Jersey

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*A non-profit, "helping hand" organization funded and administered by New Jersey physicians for the benefit of their widows and orphans.*

## Objects of the Society

The Society was founded to provide immediate financial assistance to those who have been dependent upon a deceased member, to assist a member disabled by illness or misfortune by lending money without collateral or interest, and to assist widows and orphans of deceased members who may experience adversity.

## Benefits

The Society does not pay a fixed sum upon the death of a member. The amount varies slightly depending upon the number of members on the rolls in good standing at the time an assessment is called.

The bylaws of the Society provide that the widow of a member shall receive at least 80 percent of every dollar paid in by the members. The remaining 20 percent of an assessment is used to defray necessary Society expenses, such as printing, postage, bonds for officers, and clerical assistance for the treasurer. The unexpended balance of this 20 percent is placed in the Permanent Fund to provide income which is used to aid widows and children of deceased members who need assistance. The present benefit, since the beginning of the fiscal year April 1, 1973 is \$1,400.00.

## The Permanent Fund

Since the Society was founded the Trustees have saved the amounts received from initiation fees, donations, and the unexpended balance of the aforementioned 20 percent. These funds are invested in securities to which the Trustees are restricted by state laws. These invested savings constitute the Permanent Fund. The Fund remains in a satisfactory state and produces a good yield. No portion of the Permanent Fund may be spent for any purpose whatsoever. The

income from the Permanent Fund is used to provide assistance to needy widows, orphans of deceased members, and members in need. Such assistance is in addition to the regular death benefit and may be provided for many years after the death of the member, depending upon the need.

## Payment of Benefits

Upon proof of death, a check in the full amount of the current death benefit is sent to the widow immediately. If no widow survives, the payment is made to the children of the deceased. If there are no heirs, payment is made to the estate (taxable), or as directed. Often payment has been returned to the Permanent Fund.

## Annual Cost per Member

With our present membership we lose by death 16 to 20 members each year. Assessments per death are as follows:

For a member joining the Society —

Before age 50	\$1.00
Between 50 and 55	\$2.00
Between 55 and 60	\$3.00
Between 60 and 65	\$5.00

The Society does not accept applicants over 65 years of age.

The amount of the assessment is determined solely by the age at the time of becoming a member. There is no change in the amount of the assessment per death after joining the Society. The Treasurer notifies the entire membership of the deaths, together with a statement of the member's indebtedness to the Society at that time.

## Salaries and Commissions

There are no salaried positions in this Society. The Treasurer is allowed a modest sum for clerical assistance. No one is paid commissions of any kind. The Officers and Board of Trustees give their time and service without compensation.

## Reasons for Joining the Society

This Society can best be described as a "Helping Hand Organization." It provides a sum to help carry the deceased member's family over a difficult time when ready money is not always available.



Every physician in good standing in the State of New Jersey is eligible for membership. At a small cost he can help provide aid to a professional brother in distress, or to his family; and when a member dies, it is satisfying to a physician to know he has helped provide financial assistance to the bereaved, and occasionally to a very needy family. Some members, and beneficiaries, have transferred their benefits to the Permanent Fund further to aid those unfortunate ones and are, thereafter, carried on our rolls as "Benefactors."

### How to Join the Society

The Board of Trustees welcomes new members. No medical examination is required. The application blank requires only the name of the applicant, age, address, the medical school attended, and the date of graduation.

The application must be signed by two members of the Society for Relief of Widows and Orphans who will testify that the applicant is in ordinary good health. A list of members and a supply of application blanks are available from your County Medical Society.

The completed application is sent to the Treasurer with a check for the initiation fee according to the following schedule:

If under 50 years	\$3.00
Between 50 and 55 years	\$4.00
Between 55 and 60 years	\$5.00
Between 60 and 65 years	\$7.00

## Thyroid Cancer Screening

*(The following communication and sample form were sent to us from Myron J. Shapiro, M.D., Acting Director, Section on Otolaryngology and Maxillofacial Surgery, New Jersey School of Medicine, CMDNJ, Newark Eye and Ear Infirmary, 15 South Ninth Street, Newark.)*

Readers may be aware that the Section of Otolaryngology and Maxillofacial Surgery of the New Jersey Medical School is conducting a survey of thyroid cancer following radiation therapy to the head and neck in childhood.

After a member is elected a change of residence, retirement, or military or government service does not affect membership. Once a member, always a member, provided assessments are paid. In unusual circumstances assessments may be waived according to provisions of the bylaws.

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We have held two free thyroid cancer screening programs at United Hospitals in Newark and are planning to hold several more in various communities throughout the State. This should give us a fairly good sampling of patients who have had radiation exposure but we realize that we may be missing large segments of our population who are going to their private physicians to have the same type of screening done.

Thus we are asking New Jersey practicing physicians to send information to us for incorporation in our data.

The carcinogenic effect of radiation to the thymus and skin of the neck is well known. We do not know, however, whether there is a risk associated with radiation to the nasopharynx by either external beam or by radium applicator. One of our major effects, therefore, is to determine if these patients are at risk, and

larger samples are important.

Following is a sample of the data sheet we have been using. Perhaps our readers could duplicate this for use in completing the information we are seeking. Forms are available also from Dr. Shapiro at the address given on the sample.

Thyroid Screening

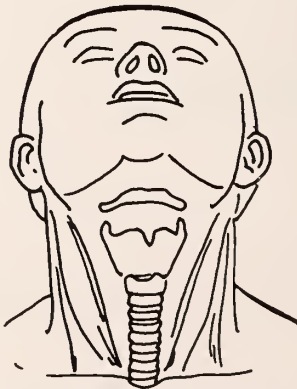
Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_  
Address: \_\_\_\_\_ Tel. #: \_\_\_\_\_  
Family Doctor: \_\_\_\_\_  
Address: \_\_\_\_\_ Tel. #: \_\_\_\_\_

1. What area of head and neck was given radiation or radium treatment?
- |                |                        |             |
|----------------|------------------------|-------------|
| Throat _____   | Skin _____             | Other _____ |
| Adenoids _____ | "Swollen Glands" _____ | _____       |
| Tonsils _____  | Thyroid _____          | _____       |
| Ears _____     | Thymus _____           | _____       |
2. At approximately what age was treatment given? \_\_\_\_\_
3. Where was treatment given: Hospital \_\_\_\_\_ Dr.'s Off. \_\_\_\_\_ Clinic \_\_\_\_\_
4. Have you had treatment for overactive thyroid with radioactive iodine? Yes No
5. Do you feel a lump in your neck? Yes No
6. Is your voice hoarse? Yes No
7. Any difficulty swallowing? Yes No



Indicate on this diagram the area and type of treatment.

Please Return To:  
Myran J. Shapiro, M.D., FACS  
New Jersey Medical School  
15 South Ninth Street  
Newark, New Jersey 07107



Indicate on this diagram enlarged lymph nodes, thyroid nodules, hoarseness.

\_\_\_\_\_  
Date  
\_\_\_\_\_  
Examiner

All information will be kept confidential

## PHYSICIANS SEEKING LOCATION IN NEW JERSEY

*The following physicians have written to the Executive Office of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.*

**ANESTHESIOLOGY**—Takao Uchida, M.D., 1545 NW 8th Avenue, Apt. #108, Miami, Florida 33136. Gifu (Japan) 1973. Board eligible. Solo, single specialty group, partnership. Available.

Margarita Bravo, M.D., 51-15 Van Kleeck Street, Apt. 2-G, Elmhurst, New York 11373. Univ. of Philippines 1969. Board eligible. Group or partnership. Available.

Wagdy Farid Aziz, M.D., 7 Hegeman Ave., Apt. 11-G, Brooklyn, New York 11212. Ein Shams Medical College (Egypt) 1964. Board eligible. Solo, partnership, single-specialty group. Available December 1977.

**FAMILY PRACTICE**—Bruce E. Yeamans, M.D., 5025 A Street, Omaha, Nebraska 68106. Creighton 1974. Board eligible. Small group or partnership. Available.

Jin Baik Chung, M.D., 823 Harned Street, Apt. 2-A, Perth Amboy 08861. Catholic Medical College (Korea) 1968. Solo, partnership, group, emergency room. Available July 1978.

Jon K. Sternburg, M.D., 777 South Mills Street, Madison, Wisconsin, 53715. George Washington University 1974. Board eligible. Group (single specialty). Available September 1978.

**GENERAL PRACTICE**—George A. Murr, III, M.D., 1611 South Broad Street, Philadelphia, Pennsylvania 19148. Hahnemann 1976. Subspecialty, emergency medicine. Group or emergency room. Available.

Terence T. Hart, M.D., 1474 Seymour Street, Apt. 5, Halifax, Nova Scotia, Canada. Subspecialty, emergency medicine. Partnership, group, or emergency room. Available.

Abdul Waheed, M.D., 5914 Shoshone Avenue, Encino, California 91316. Khyber Medical College (Pakistan) Partnership or group. Available.

Dan J. Hanco, M.D., 10 Muirhead Road, Apt. 1701, Willowdale M2J 4P9, Ontario, Canada. University of Toronto 1976. Partnership, school health, emergency room. Available.

John D. Gawlik, M.D., 464 Chapman Street, Irvington, N.J. 07111. St. Louis University 1969. Group or partnership. Available.

**INTERNAL MEDICINE**—Robin O. Motz, M.D., 1297 Dickerson Road, Teaneck 07666. Columbia University 1975. Single or multi-specialty group, research. Available July 1978.

Jeffrey M. Shapiro, M.D., 2991 School House Lane, Apt. #534E, Philadelphia, Pennsylvania 19144. University of Buenos Aires 1963. Subspecialty, gastroenterology. Board certified (IM). Solo, partnership, group. Available July 1978.

Myron A. Shoham, M.D., M.O.Q. 3011, Camp Lejeune, North Carolina 28542. Boston 1971. Subspecialty, gastroenterology. Board certified (IM). Group or partnership. Available July 1978.

Ira Spiler, M.D., 27 Sutherland Road, Brighton, Massachusetts 02146. Einstein 1971. Subspecialty, endocrinology. Board certified (IM). Group, partnership, or geographic (full time). Available July 1978.

John J. Halpin, M.D., 1089 Elmore Avenue, Columbus, Ohio 43224. Georgetown 1971. Subspecialty, hematology/oncology. Board certified (IM). Group or partnership. Available July 1978.

Bruce E. Sherling, M.D., 28-B Warren Drive, Edison 08817. NYU 1973. Subspecialty, pulmonary diseases. Board certified (IM). Group or hospital-based. Available July 1978.

Yune-Gill Jeong, M.D., 6-B Booker Creek Apt., Chapel Hill, North Carolina 27514. Chun Nam (Korea) 1970. Subspecialty, pulmonary medicine. Board certified (IM). Hospital-based or geographic full-time pulmonary subspecialist. Available July 1978.

Abdul Rashid Gangoo, M.D., 4 Fairhavenmall, Apt. 14-E, Mineola, New York 11501. University of Kashmir (India) 1969. Subspecialty, infectious diseases. Board eligible (IM). Solo, partnership, group, public health, emergency room. Available July 1978.

Raja G. Bhat, M.D., 1806 Coachmen East, Lindenvold 08021. Christian Medical College, Vellore (India) 1972. Solo, partnership, group. Available July 1978.

Navinchandra M. Amin, M.D., 36 Oakville Drive, Apt. 1-A, Pittsburgh, Pennsylvania 15220. Grant Medical College, Bombay (India) 1961. Subspecialty, cardiovascular diseases. Board certified (IM). Group, partnership, institution. Available November 1977.

Marvin B. Padnick, M.D., 38 Steamboat Road, Great Neck, New York 11024. Rush Medical College 1973. Subspecialty, cardiovascular diseases. Partnership or group. Available June 1978.

Chun Wen Yang, M.D., 23 Ashwood Drive, Livingston 07039. Kaohsiung (Taiwan) 1969. Subspecialty, hematology/oncology. Board certified (IM). Group. Available July 1978.

Hong Joon Kim, M.D., 2014 S. 102nd Street, Apt. 109-C, West Allis, Wisconsin 53227. Seoul National University (Korea) 1970. Board eligible. Partnership or group. Available July 1978.

Myron A. Shoham, M.D., MOQ 3011, Camp Lejeune, North Carolina 28542. Boston University 1971. Subspecialty, gastroenterology. Board certified (IM). Partnership or group. Available August 1978.



Uday V. Gupte, M.D., 1012 Clintonville Street, White-stone, New York 11357. T.N. Medical College, Bom-bay (India). Subspecialty, gastroenterology. Board certified (IM). Partnership or group. Available Janu-ary 1978.

Gerald Einaugler, M.D., 2270 Ocean Avenue, Brook-lyn, New York 11229. University of Bologna (Italy) 1975. Board eligible. Solo, partnership, group. Avail-able July 1978.

M. Ganesharajah, M.D., 50 South Munn Ave., Apt. 420, East Orange 07018. Ceylon 1970. Subspecialty, nephrology. Board eligible. Group, partnership, solo. Available.

Robert E. Greenspan, M.D., 1240 Mulford Road, Columbus, Ohio 43212. University of Maryland 1971. Group, partnership, research. Available July 1978.

Barry Elliot Field, M.D., 4461 Pacific Coast Highway, Apt. C-205, Torrance, California 90505. Einstein. Subspecialty, gastroenterology. Board certified (IM). Group or partnership. Available September 1978.

NEPHROLOGY—Ralph J. Carciana, M.D., 2556 Alderney Lane, Winston-Salem, North Carolina 27103. Tufts 1974. Board eligible. Group. Available July 1978.

NEUROLOGY—Sadasivam Modali, M.D., 51-55 Van Kleeck Street, Apt. 3-J, Elmhurst, New York 11373. Kurnool Medical College (India) 1964. Board eligible. Group, partnership, or hospital practice. Available.

Lester Hershman, M.D., 500 East 85th Street, Apt. 3-F, New York, New York 10028. Mt. Sinai (NYC) 1974. Board eligible. Group, partnership, solo. Avail-able July 1978.

Peter J. Barbour, M.D., 1711-A Marshall Court, Los Altos, California 94022. Temple 1974. Group or partnership. Available July 1978.

OBSTETRICS/GYNECOLOGY—R. George Cherian, M.D., 3450-21N Wayne Avenue, Bronx, New York 10467. Kasturba (India) 1970. Board eligible. Solo or partnership. Available.

Louis J. Freedman, M.D., 210 Locust Street, Apt. 12-A, Philadelphia, Pennsylvania 19106. University of Pennsylvania. Group (specialty) or partnership. Available July 1978.

Akbar Omar, M.D., 85 Riverdale Avenue, Apt. A-642, Yonkers, New York 10701. Dow, Karachi (Pakistan). Solo, partnership, or group. Available July 1978.

Leonard Pass, M.D., 6 Douglas Mowbray Road, Peek-skill, New York 10566. Board certified. Solo, partnern-ship, or group. Available September 1977.

Parimal S. Bhayani, M.D., 1275 Rock Avenue, Apt. KK-7, North Plainfield 07060. Univ. of Bombay 1968. Board eligible. Group or partnership. Available.

Wook Chung, M.D., 950 49th Street, Apt. 6-J, Brook-lyn, New York 11219. Catholic Medical College (Korea) 1967. Group, partnership, or solo. Available July 1978.

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N. D. Karmali, M.D., c/o Daniel Boone Clinic, Harlan, Kentucky 40831. T.N. Medical College, Bombay (India) 1971. Board eligible. Partnership or group. Available January 1978.

**OPHTHALMOLOGY**—Frederick C. Blades, M.D., 499 River Road, Fair Haven 07701. George Washington University 1969. Board eligible. Part-time, close to Red Bank. Available.

Davinder Singh Rehsia, M.D., 504-671 William Avenue, Winnipeg R3E 0Z2, Manitoba, Canada. Amritsar, Punjab (India) 1969. Board eligible. Group, partnership, or emergency room. Available. December 1977.

Howard Jay Gross, M.D., 3115 Breton Avenue, Davis, California 95616. George Washington University 1971. Board eligible. Solo, partnership, group. Available April 1978.

Allan Stuart Markowitz, M.D., 3535 Rochambeau Avenue, Apt. 2-L, Bronx, New York 10467. Einstein 1974. Board eligible. Group, partnership, solo, or institutional. Available July 1978.

**ORTHOPEDIC SURGERY**—Michael Hahn, M.D., 85 Schuyler Drive, Edison 08817. NYU (Downstate) 1969. Board Eligible. Group or partnership. Available.

Jeffery H. Phillips, M.D., 3450-23 Wayne Avenue, Bronx, New York 10467. Einstein 1974. Group or partnership. Available July 1978.

Alfred C. Lotman, M.D., 1640 Johnson Avenue, Apt. 162-B, Petersburg, Virginia 23801. Tulane 1971. Board certified. Group. Available.

**PATHOLOGY**—Vasundhara G. Bindiganavile, M.D., 42 Walnut Street, Montclair 07042. Bangalore Medical College (India) 1969. Group or institutionally-based. Available July 1978.

Surabhan Ratanasen, M.D., 156 Corliss Avenue, Apt. 706, Johnson City, New York 13790. Chulalongkorn, Bangkok (Thailand) 1971. Board eligible. Solo, partnership, or group. Available October 1977.

Moo Keun Lee, M.D., 120 Randolph Road, Apt. #48, Plainfield 07060. Yonsei (Korea) 1968. Group or partnership. Available July 1978.

**PEDIATRICS**—Allen S. Retirado, M.D., 639 Albany Avenue, Apt. 4-J, Brooklyn, New York 11203. U.E. College of Medicine (Philippines) 1971. Board eligible. Group, partnership, hospital or institutionally based. Available.

Johannes B. Lukito, M.D., 2101 Canarsie Road, Brooklyn, New York 11236. University of Indonesia 1969. Board eligible. Subspecialty, hematology. Solo, partnership, or group. Available January 1978.

Susan R. De Castro, M.D., East 16th Street, Alma, Georgia 31510. Far Eastern (Philippines) 1965. Board eligible. Group, partnership, solo, or public health. Available April 1978.

Ferdous Kazemi, M.D., 301 East 64th Street, Apt. 9-J, New York City 10021. Tehran (Iran) 1969. Board certified. Group, partnership, solo. Available.

Richard Lander, M.D., 115 Old Short Hills Road, Apt. 335, West Orange 07052. Guadalajara (Mexico) 1974. Board eligible. Group, partnership, solo. Available July 1978.

**RADIOLOGY**—Sun Hyung Park, M.D., 230 Elruth Court, Apt. 86, Girard, Ohio 44420. Yonsei University (Korea) 1972. Board eligible. Solo, partnership, group, institutional. Available November 1977.

**SURGERY**—George E. Wilkinson, Jr., M.D., 98 Marchmont Crescent. Edinburgh EH9 1HD, Scotland. CMDNJ 1972. Board eligible. Group. Available.

Jorge Antonio Melendez, M.D., 1 Hillside Drive, Batavia, New York 14020. San Agostin University (Peru) 1967. Board certified. Partnership, group, institutionally based. Available August 1978.

Sham Yung, M.D., 1035 Beach Road, Apt. B-10, Cheektowaga, New York 14225. Chung Shan Medical College (Taiwan) 1972. Board eligible. Solo, partnership, group, emergency room. Available December 1977.

Irvathur Narasimha Nayak, M.D., 115 Old Short Hills Road, Apt. 526, West Orange 07052. Stanley Medical College, Madras (India) 1963. Board eligible. Solo, partnership, group. Available January 1978.

James Fredrick Davison, 3699 Kendall Avenue, Cincinnati, Ohio 45208. St. Louis University 1972. Special interest, urological surgery. Partnership or group. Available July 1978.

Richard J. Winkle, M.D., 114 Country Club Road, Willingboro 08046. Cornell 1960. Board certified. Subspecialty, thoracic and vascular surgery. Available.

Martin Gewecke, M.D., 143-11 Kirkbride Road, Voorhees Township 08043. Munich 1967. Board eligible. Group, partnership, hospital. Available January 1978.

Manuel S. DiJamco, M.D., 1432 Arch Street, Apt. B-201, Norristown, Pennsylvania 19401. Manila Central University (Philippines) 1952. Group, partnership, or solo. Available July 1978.

**UROLOGY**—Bruce Devon, M.D., 675 Delaware Avenue, Buffalo, New York 14202. Tufts 1973. Board eligible. Solo, partnership, or group. Available July 1978.

Louis D'Amico, M.D., 1061 Renfield Road, Cleveland Heights, Ohio 44121. Hahnemann 1973. Group, partnership, solo. Available July 1978.

V. R. Goli, M.D., 195 Deveron Crescent, London, Ontario, Canada N52 4J4. Guntur (India) 1962. Board eligible. Group, partnership, or solo. Available July 1978.

## 212th Annual Meeting May 6-9

*Headquarters Hotels*

**Holiday Inn — Howard Johnson's Regency**

**Atlantic City**



# CLINICAL NOTE

## Cerumen as a Lubricant\*

William Weber, M.D., and  
Sharir Raz, M.D., Newark

The otolaryngologist frequently is called upon to remove a foreign body from the ear canal. Most foreign objects are seen in the younger age group and are easily discernible. Some are unusual and even difficult to identify.<sup>1,2,3</sup>

This paper describes a unique otic foreign body, the presence of which could provide a clue to the life style of the patient.

### Case Report

A twenty-six-year-old male presented with a complaint of right ear pain over the last two days. On examination each of his ear canals was occluded by a dark foreign body, which upon removal proved to be the rubber tip of a one cc tuberculin syringe plunger (Figure 1). Even at that point the patient denied knowledge of how this occurred.



Three similar cases of retained rubber tips in the ear canal in admitted drug users later were brought to our attention.

### Discussion

Self-inflicted disorders may occasionally be indistinguishable from "true" disease processes.

When a reasonably intelligent person denies knowledge of two foreign bodies in his ears he most likely is not telling the truth. And indeed, on investigating this question further, it became apparent that a drug addict habitually may insert syringe plungers into his ear canal for lubrication prior to the drug injection. It is not clear why the patient presented at our clinic. Was it to rid himself of a disturbing foreign body, or perhaps to correct his natural source of lubricant?

### Summary

Drug addicts may be identified indirectly if a part of a syringe plunger is found in their external canal, after it has separated during the process of lubrication prior to drug injection.

### References

1. Graham JK, Watkins WJ: Foreign body of the external ear canal. *J Louisiana State Med Soc* 120:202-203, 1968.
2. Senocak F: A case of tympanic foreign body. *Arch Otol* 81:319, 1965.
3. Beselin O: On very small foreign bodies. *HNO (Hals-Nasen-Ohren-Heilkunde, Berlin, W. Germany)* 12:32, 1964.

\*From the Section of Otolaryngology of the New Jersey Medical School, CMDNJ, Newark. Dr. Weber is now in private practice in Easton, Pennsylvania (Lafayette Towers, Suite 127)

### A Different Look at Medicaid

Your attention is directed to an *AMA News Release* of August 3, which reprinted from the Provincetown, Mass. *Advocate* an article entitled "How U.S. Turns Medicaid into 'Second Class' Medicine." The commentary was authored by one of our members from the Passaic County Medical Society, Dr. Robert A. Goldstone. Interested readers may obtain a copy from Dr. Goldstone—646 East 28th St., Paterson 07504—(201) 523-7878.

# *Lifesaving Partnership... Against Cancer Quackery*

The anguish associated with cancer is compounded by the cancer quack. False hopes—harmful delays—devastating expenses—deceptive diagnoses—loss of life—these are hazards facing the cancer patient desperate enough to seek a cancer quack.

*The problem:* how to divert the patient from this tragic encounter.

As medical guide, family counselor, trusted friend—you, *doctor*, play a major role in the fight against cancer quackery.

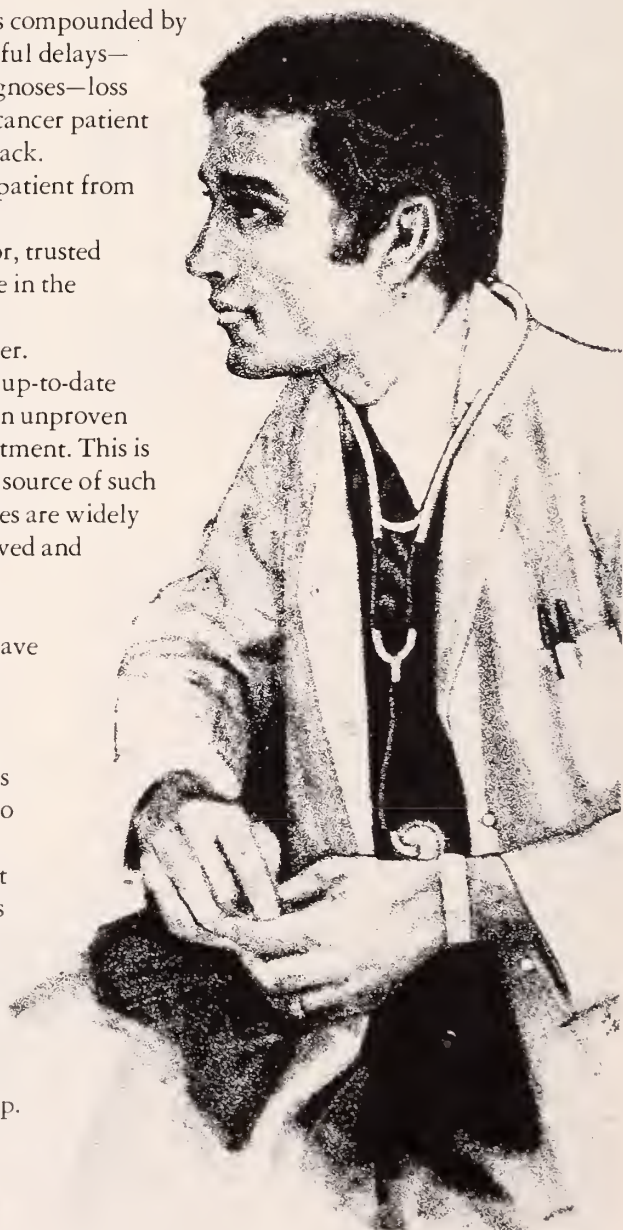
We are here to serve as your partner.

Our National Office maintains an up-to-date central clearinghouse for materials on unproven methods of cancer diagnosis and treatment. This is a unique operation and the principal source of such information in the country. Its services are widely used. Hundreds of inquiries are received and answered from all segments of the community, from coast to coast.

To trigger grass-roots action, we have formulated a model State Cancer Remedy Act designed to control the promotion and sale of unproven methods of cancer management. This has helped to inspire some 20 states to enact or consider legislation against cancer quackery—with active support from the medical community. Copies of the model act, as well as copies of laws in effect, are available through our National and Division offices.

In these actions against cancer quackery, as in all our efforts against cancer, ours is a lifesaving partnership.

*American Cancer Society* ✕



# LETTERS TO THE JOURNAL

## A Mess of Pottage?

July 18, 1977

Dear Editor:

The resolution to act positively and affirmatively on the Garramone legislative package by the Medical Society of New Jersey is a shameful piece of business, because it includes support of Garramone bill 1245, which promises immunity for physicians who report suspicions of incompetence about other physicians to the State Board of Medical Examiners.

Admittedly, tort reform is desirable, but not so desirable that it should be voted in conjunction with a bill that threatens American freedoms and turns colleagues into potential informers. This package is not worthy of the support of the physicians of the state of New Jersey. It should be possible to get tort reform without our having to sell our birthright for a mess of pottage.

(signed) Charles Harris, M.D.

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## The Physician Assistant

August 1, 1977

Dear Editor:

In the June issue of *The Journal* of the Medical Society of New Jersey the Editor chided the profession for shutting up like a clam and not expressing its opinions. I am afraid that many members of the Medical Society have rightly thought that I open my mouth too frequently, but as long as the Editor insists I will express my opinion about the need to license physician assistants.

As a physician who practiced for 35 years in New Jersey, and as the former Medical Direc-

tor of a large hospital, I would like to object strongly, as I have in the past, to the need for physician assistants and to the bill which would give them a license. First I wish to state that the finest professional assistant a doctor ever had or will have is a graduate nurse and I have found this opinion to be held by the physicians I have asked who are engaged in the private personal practice of medicine and who deliver most of the medical services in the State of New Jersey. I realize, however, that some academicians and physicians in large clinics who have a different concept of "personal medical care" may not agree with me.

It was pointed out to the faculty of the Rutgers Medical School by the New Jersey Hospital Association, the New Jersey Nurses' Association, the Medical Society of New Jersey and the State Board of Medical Examiners that there was no proven need for physician assistants at the time the program was first proposed; and that the \$200,000 federal grant and the proposed state budget for the program of \$751,441 for 1977, \$1,823,256 for 1978 and \$4,843,848 for 1981 could be spent better on enlarging the medical schools to train more doctors or on nursing schools to provide more graduate nurses who have proved their ability to provide excellent medical care when working with physicians.

It has been suggested that the new physician assistants, in their striking colored uniforms, should receive \$2,000 to \$3,000 a year more than graduate nurses. As the Medical Director of the Margaret Hague Hospital I spent considerable time in attempts to obtain an adequate nursing staff and adequate salaries for nurses. I have to protest even the consideration of paying more (or even the same salary) to one of the recent physician assistant graduates than you would to an experienced staff nurse. The fact that the state accepted the federal money and spent additional hundreds of thousands of dollars of state funds is a poor argument for continuation of this program, the need for which was never proved; nor is it a good argument for licensing the graduates.

(signed) Joseph P. Donnelly, M.D.



# ANNOUNCEMENTS

## Graduate Course in Anesthesiology

The Brookdale Hospital Medical Center in Brooklyn is offering two graduate symposiums in anesthesiology—October 29 and November 5. Topic for the first program is "Coagulopathies in the Operative Patient and Blood Component Therapy." The second program presents "Fetal Monitoring and Anesthetic Management in High-Risk Pregnancy and Fetal Distress." The sessions run from 8:30 a.m. to 12:30 p.m. and the fee for each is \$20; preregistration is required. Each symposium will allow four credit hours in Category I of the Physician's Recognition Award. For additional information, please communicate with William Mackler, M.D., Brookdale Hospital Medical Center, Office of Continuing Education, Linden Boulevard, Brooklyn 11212—(212) 240-5317.

## Conference on Learning Disorders

On October 29 the Department of Pediatrics of the Medical College of Pennsylvania will offer a one-day conference on children with learning disorders—alternative pathways. The program will consist of lectures, small group discussion sessions, and a panel discussion on controversies in the concept of learning disabilities. Another panel will consider the costs involved and the resources available for these children. Other topics include "Influences of Early Environmental Facts on Development," "Alternative Educational Strategies for Children with Learning Disorders," and the "Management of Hyperactive Children." The fee is \$35 and includes luncheon. Registration is limited. For information write to the Office of Medical Education, the Medical College of Pennsylvania, 3300 Henry Avenue, Philadelphia 19129 or telephone (215) 842-7118.

## Seminar on Anesthesiology

From 8 a.m. to 3:30 p.m., on Saturday, November 12, Helene Fuld Medical Center in Trenton

will present a seminar in anesthesiology, supported in part by a grant from Pfizer Laboratories. The topics offered by guest speakers will include "Plexus Anesthesia," "Management of Pain," "Malignant Hyperthermia," "Renal and Anesthetic Management of the Surgical Patient," and "Health Hazards of Anesthesia Pollution and Control." Advance registration is required. The fee is \$10 (\$5 for residents and students) and includes buffet luncheon. Five credit hours will be given in Category I of the AMA Physician's Recognition Award. For additional information and registration form, please communicate with Mrs. Diana Weigand, Helene Fuld Medical Center, 750 Brunswick Avenue, Trenton 08638 — (609) 396-6575.

## Cancer Seminar

On November 12 and 13, under the sponsorship of the American Cancer Society, a seminar entitled "Metastatic Cancer: End of the Road or Start of the Journey" will be presented at the Marriott Hotel in Saddle Brook. Lectures will be offered on the following topics:

Newer Diagnostic Techniques in Cancer

Recent Advances in Long-Term Management of Leukemia, Lymphoma, and Hodgkins Disease

Management of Metastatic Carcinoma of Solitary Cervical Lymph Nodes

Ovarian Cancer

Metastatic Breast Cancer: Radiation Therapy, Chemotherapy, and Endocrinology

Chemotherapy in Treatment of Metastatic Colon Cancer

The Patient's Right To Know—Participation in Management

Current Role of Immunology in Therapy of Cancer

Management of Pain

Advances in Management of Prostatic Carcinoma

Application has been made for CME credit in the American Academy of Family Physicians and the Association of Osteopathic Physicians,

and in Category I of the AMA Physician's Recognition Award.

The fee, which includes luncheon on Saturday and coffee/pastry and "coke" breaks on each day, is \$15. Advance registration is requested.

For additional information, please communicate with Ms. Alex Kubiacyk, Director of Professional Education, American Cancer Society, 2700 Route 22 East, Union, New Jersey 07083.

### **Seminar on Clinical Public Relations**

On November 13 the Inter-Agency Commission on Emergency Medical Care will sponsor a seminar on clinical public relations—the harmonizing of pre-hospital and emergency room relationships. Some of the topics to be presented are: Relationship between Emergency Department and Pre-Hospital Emergency Service Personnel, Pre-Hospital Care of Multiple Injuries, Pre-Hospital Care of Injuries to the Extremities, Management of Obstructed Airway, Positioning of the Respiratory Distress and Cardiac Patient, Pre-Hospital Management of the Punctured Lung, and Medico-Legal Implications in Pre-Hospital Care. Fee for the program, which is limited to 500 registrants, is \$6. Application has been made for credit in Category I of the AMA Physician's Recognition Award. For information please write to the Inter-Agency Commission on Emergency Medical Care, 315 West State Street, Trenton 08618 — (609) 394-3154.

### **Infectious Disease and Immunology**

Under the sponsorship of The Children's Hospital of Philadelphia a seminar on infectious disease and immunology will be held on November 18 and 19 at the hospital (34th Street and Civic Center Boulevard). The program is designed to familiarize the practicing pediatrician and family practitioner with recent advances in infectious diseases and immunology. Included will be case presentations, didactic lectures, and panel discussions. A fee will be charged and application has been made for credit in Category I of the AMA Physician's Recognition Award. For informa-

tion please communicate with Patrick S. Pasquariello, Jr., M.D., The Children's Hospital of Philadelphia at the above address — (215) 387-6000, ext. 307.

### **Medicine and Government**

On December 14, at Cedar Gardens Restaurant, Route 33 (Hamilton Square), Trenton, the Mercer County Medical Society will present a program on "Current Trends in Medicine and Government." The scheduled guest speaker is Otis R. Bowen, M.D., Governor of Indiana. The session will convene at 6:30 p.m. with cocktails; dinner will be served at 7:30 p.m. All physicians are invited to participate. The cost is \$20 and a check, payable to the Mercer County Medical Society, should accompany your request for reservation. Please communicate with Mrs. F. Q. Nicholas, Executive Secretary, Mercer County Medical Society, 212 Scotch Road, Trenton 08626 (609) 392-1123.

### **Plastic Surgery Conference in Egypt**

The 10th International Congress on Ophthalmic and Otolaryngic Plastic Surgery will be held March 10 through 19, 1978 in Egypt. All scientific sessions will be held in Cairo. The American lecturer will be Gerald Shannon, M.D., Chairman of the Oculoplastic Department, Wills Eye Hospital, Philadelphia. A complete program and other details of the Congress are available from Ralph L. Dicker, M.D., 245 East 63rd Street, New York 10021.

### **Graduate Course in Radiology**

At the Duke University Medical Center in Durham, from April 3 to 7, 1978, the Department of Radiology, Duke University Medical Center, will present its 6th annual postgraduate course on "Radiology of Neoplastic Diseases." Emphasis will be on personalized, tutorial teaching by recognized authorities, using original roentgenograms and supplemental slide material. There will be ample opportunity for discussion. The subject matter will include all facets of neoplastic disease, including comprehensive coverage of diagnostic techniques. A detailed abstract book with references will be

provided. Twenty-seven credit hours will be given in Category I of the AMA Physician's Recognition Award. Inquiries should be addressed to the Program Director, Robert McLelland, M.D., Radiology—Box 3808, Duke University Medical Center, Durham, North Carolina 27710.

### Preceptorships for Practicing Physicians

The Medical College of Pennsylvania will offer "Preceptorships for Practicing Physicians" during the 1977-1978 academic year. In an effort to meet individual continuing medical education needs, the program is designed to

give both the general practitioner and the specialist the opportunity to update present skills and to learn new patient care techniques. Sessions will be available in anesthesiology, medicine, neurology, obstetrics/gynecology, pathology, pediatrics, psychiatry, radiology, and surgery. Hour-for-hour credit will be allowed in Category I of the AMA Physician's Recognition Award and application for credit has been made to the AAFP. For further information, please communicate with Sylvia S. Yedinsky, M.D., Assistant Dean for Continuing Medical Education, The Medical College of Pennsylvania, 3300 Henry Avenue, Philadelphia 19129.

## MEETINGS OF MEDICAL INTEREST

This listing is compiled through the cooperation of the Committee on Medical Education of The Medical Society of New Jersey, the Academy of Medicine of New Jersey, the New Jersey Chapter of the American Academy of Family Physicians, and the Office of Continuing Medical Education of the College of Medicine and Dentistry of New Jersey. For information on accreditation, please contact the sponsoring organization(s), indicated by italics—last line of each item.

Oct.

12 **Dreams in Psychotherapy**  
8:30-10:30 p.m. — Guido's Restaurant, Hackensack  
(*North Jersey Psychiatric Society and AMNJ*)

12 **Hyperlipidemia**  
1-3 p.m. — Christ Hospital, Jersey City  
(*Christ Hospital, AMNJ and AAFP*)

12 **Proper Use of Antibiotics**  
1:30 p.m. — John E. Runnells Hospital, Berkeley Heights  
(*AMNJ and AAFP*)

12 **Psychiatric Aspects of Endocrinology**  
3:15 p.m. — Fair Oaks Hospital  
(*AMNJ and AAFP*)

12 **Endocrine Hypertension: Update 1977**  
1-2:30 p.m. — VA Hospital, Lyons  
(*VA Hospital and AMNJ*)

12 **Degenerative Diseases of Old Age**  
9 a.m.-4:30 p.m. — VA Hospital, East Orange  
(*VA Hospital and AMNJ*)

12 **Multidisciplinary Approach to Cancer**  
19 2-6 p.m. — Newark Beth Israel Medical Center  
26 (*Newark Beth Israel Medical Center and AMNJ*)

12 **Internal Medicine and Therapeutics**  
19 9-11 a.m. — Middlesex General Hospital,  
26 New Brunswick  
(*Middlesex General Hospital and AMNJ*)

12 **Q Waves: Their Clinical Implication**  
19 **Thromboembolism Disease**  
26 **Clinical Pathology Conference**  
9:30-11 a.m. — Bergen Pines County Hospital, Paramus  
(*Bergen Pines County Hospital and AMNJ*)

12 **Continuing Medical Education Program**  
19 10:30-11:30 a.m. — Clara Maass Memorial Hospital,  
26 Belleville  
(*Clara Maass Memorial Hospital and AAFP*)

12 **Courses for Psychiatrists**  
19 8-10 p.m. — Hackensack Hospital  
26 (*N.J. Psychoanalytic Society and AMNJ*)

12 **Valvular Heart Disease Indicated Therapy**  
19 **Inflammatory Bowel Disease**  
26 **Endocarditis**  
9-11 a.m. — Riverview Hospital, Red Bank  
(*Riverview Hospital and AMNJ*)

13 **Atrial Myxoma**  
8-9 p.m. — Deborah Heart and Lung Center, Browns Mills  
(*Burlington County Medical Society and AMNJ*)



- 13 **High Risk Obstetrics**  
12 noon-1 p.m. — St. Mary's Hospital, Orange  
(*St. Mary's Hospital and AMNJ*)
- 13 **Blood Component Therapy**
- 17 **Congenital Heart Defects**
- 20 **Surgical Infections**
- 24 **Swan-Ganz Catheter**
- 27 **Pulmonary Function Tests**
- 31 **Ventilators and Respirators**  
5-6 p.m. — St. Francis Medical Center, Trenton  
(*St. Francis Medical Center*)
- 13 **Difficult Upper Intestinal Bleeding**
- 20 **Non-Hodgkin's Lymphomas — Part I**
- 27 **Non-Hodgkin's Lymphomas — Part II**  
3:30-4:30 p.m. — Burlington Co. Memorial Hospital,  
Mount Holly  
(*Burlington Co. Memorial Hospital*)
- 13 **Pediatric Allergy Course**
- 20 11 a.m.-12 noon — Children's Hospital of Newark
- 27 (*Children's Hospital of Newark and AMNJ*)
- 13 **Laboratory Considerations of Pulmonary Diseases**  
6:15 p.m. — Bridgeton Hospital  
(*Bridgeton Hospital*)
- 14 **Psychiatric Lecture Series**
- 21 1:30-5 p.m. — Trenton Psychiatric Hospital
- 28 (*Trenton Psychiatric Hospital and AMNJ*)
- 14 **Preservation of Ischemic Myocardium**  
11 a.m.-12 noon — Ciba-Geigy, Pharmaceuticals Div.,  
Summit  
(*Ciba-Geigy and AMNJ*)
- 15 **Genetics for the Clinician**  
9 a.m.-1 p.m. — Morristown Memorial Hospital  
(*Morristown Memorial Hospital and AMNJ*)
- 17 **Current Treatment of Burns**  
12 noon — Hospital Center at Orange  
(*AMNJ and AAFP*)
- 17 **Neuroscience Conferences**
- 24 11:30 a.m.-12:30 p.m. — Bergen Pines County
- 31 Hospital, Paramus  
(*Bergen Pines County Hospital and AMNJ*)
- 18 **Coronary Artery Disease**  
12 noon — St. Mary's Hospital, Orange  
(*AMNJ and AAFP*)
- 18 **Northern Regional Chest Conferences**  
7:30-9:30 p.m. — St. Michael's Hospital, Newark  
(*New Jersey Thoracic Society and AMNJ*)
- 18- **AMA Regional CME Program**
- 19 Hershey Motor Lodge, Hershey, Pa.  
(*Hahnemann, Jefferson, Medical College of Pa.,  
CMDNJ, Howard, Penn State, Rutgers, Temple,  
Univ. of Pa., Univ. of Pittsburgh, Pa. Medical Society*)
- 18 **Treatment of Hypertension Diabetes**  
9-10 a.m. — Holy Name Hospital, Teaneck  
(*Holy Name Hospital and AMNJ*)
- 18 **Psychiatric Case Conference**
- 25 7:30-9:30 a.m. — Trenton Psychiatric Hospital  
(*Trenton Psychiatric Hospital and AMNJ*)
- 18 **Continuing Education Lectures in Psychiatry**
- 19 1-3 p.m. — Ancora Psychiatric Hospital, Hammonton  
(*Ancora Psychiatric Hospital and AMNJ*)
- 18 **Chemotherapy — Head and Neck Cancer**  
6-10 p.m. — Pascack Valley Hospital, Westwood  
(*Bergen County Society of Otolaryngologists  
and AMNJ*)
- 19 **Adjuvant Chemotherapy in Neoplastic Disease**  
8-9 a.m. — So. Ocean County Hospital, Manahawkin  
(*Burlington County Memorial Hospital*)
- 19 **The Suicidal Patient**  
1 p.m. — Trenton Psychiatric Hospital  
(*AMNJ and AAFP*)
- 19 **Hypovolemia, Hypovolemic Shock in the Neonate**  
2-9 p.m. — Ramada Inn, Rochelle Park  
(*St. Joseph's Hospital, Paterson and AMNJ*)
- 19 **Acute Renal Failure**  
1-3 p.m. — Christ Hospital, Jersey City  
(*Christ Hospital and AMNJ*)
- 19 **Trends in Cardiology**  
10 a.m.-noon and 2:15-4:30 p.m. — Watchung View  
Inn, Bridgewater  
(*Rutgers Medical School, Raritan Valley Hospital,  
and AMNJ*)
- 19 **Updating Peripheral Neuropathy**  
1-2 p.m. — VA Hospital, Lyons  
(*VA Hospital, Lyons, and AMNJ*)
- 5 **Cardiology Conferences**
- 19 4-6 p.m. — Rutgers Medical School, Piscataway  
(*CMDNJ-Rutgers Medical School and AMNJ*)
- 19 **CME Program for Family Practitioners**  
9-11 a.m. — West Jersey Hospital, Voorhees  
(*West Jersey Hospital and AAFP*)
- 19 **Problem-Solving Clinic**  
11 a.m.-3:30 p.m. — Pennington Club, Passaic  
(*Passaic Valley PSRO and AMNJ*)
- 19 **Failure in Sex Therapy**  
8:30-10:30 p.m. — The Manor, West Orange  
(*Tri County Chapter, N.J. Psychiatric Association  
and AMNJ*)
- 19 **A New Look at Some Old Diseases**  
9 a.m.-3 p.m. — Rutgers Medical School, Piscataway  
(*Arthritis Foundation, NJ Chapter and AMNJ*)
- 19 **Special Problems in Neurology**  
7-10 p.m. — VA Hospital, East Orange  
(*VA Hospital and AMNJ*)
- 20 **Viral Etiology of Cancer**  
1:45-5:30 p.m. — Drew University, Madison  
(*Ciba-Geigy and AMNJ*)

- 20 **Management of Patient with Diarrhea**  
5-6:30 p.m. — Somerset Hospital, Somerville  
(*Somerset Hospital and AMNJ*)
- 20 **Assertive Training**  
9:30 a.m.-3:30 p.m. — Trenton Psychiatric Hospital  
(*Trenton Psychiatric Hospital and AMNJ*)
- 21 **Cardiac Rehabilitation**  
5 p.m. — Holiday Inn, Deepwater  
(*AMNJ and AAFP*)
- 24 **Outpatient Management — Urology**  
8 p.m. — Warren Hospital  
(*AMNJ and AAFP*)
- 25 **Pulmonary Infiltrates and Allergy in the Surgical Patient**  
8-10 p.m. — Englewood Men's Club  
(*Englewood Surgical Society and AMNJ*)
- 25 **Clinical Pathological Conference**  
1-2 p.m. — Trenton Psychiatric Hospital  
(*Trenton Psychiatric Hospital and AMNJ*)
- 26 **The American Diabetes Association**  
All Day — Morristown Memorial Hospital  
(*Morristown Memorial Hospital, AMNJ, and American Diabetes Assoc.*)
- 26 **Clinical Hypnosis**  
1-5 p.m. — Ramada Inn, Clark  
(*Rutgers Medical School and AMNJ*)
- 26 **Appendicitis in the Adolescent Patient**  
1 p.m. — Christ Hospital, Jersey City  
(*Christ Hospital*)
- 26 **Bleeding Diseases**  
11:30 a.m. — Rahway Hospital  
(*AMNJ and AAFP*)
- 26 **Medical/Legal Aspects of Medicine and Surgery**  
3:15 p.m. — Fair Oaks Hospital, Summit  
(*AMNJ and AAFP*)
- 26 **Radiology**  
8-9 a.m. — So. Ocean County Hospital, Manahawkin  
(*Burlington Co. Memorial Hospital and AAFP*)
- 27 **Advances in Newborn Infections**  
9:30 a.m. — Newark Beth Israel Medical Center  
(*AMNJ and AAFP*)
- 27 **Retropubic Prostatectomy**  
12 noon-1 p.m. — St. Mary's Hospital, Orange  
(*St. Mary's Hospital and AMNJ*)
- 28 **Anti-Psychotic Medications**  
1-2 p.m. — VA Hospital, Lyons  
(*VA Hospital, Lyons, and AMNJ*)
- 28 **Proper Use of Antibiotics**  
12:30 p.m. — Hamilton Hospital, Trenton  
(*AMNJ and AAFP*)
- 29 **Annual Respiratory Care Symposium**  
9 a.m.-1 p.m. — Rutgers Medical School, Piscataway  
(*N.J. State Society of Anesthesiologists and AMNJ*)

Nov.

- 1 **Community Medicine**  
9:30-10:30 a.m. — Overlook Hospital, Summit  
(*Overlook Hospital and AAFP*)
- 1 **Dermatology**  
9 a.m. — Freehold Area Hospital  
(*AMNJ and AAFP*)
- 1 **Seventh Annual Seminar — Emergency Medicine**
- 2 All day — Hyatt House, Cherry Hill  
(*ACEP/EDNA*)
- 2 **Chronic Pain — A Medical Nemesis**  
8-10 p.m. — Seton Hall University, So. Orange  
(*Mental Health Assoc. of Essex County and AMNJ*)
- 2 **Diabetes**  
1 p.m. — Christ Hospital  
(*AMNJ and AAFP*)
- 2 **Multidisciplinary Approach to Cancer**
- 9 2-4 p.m. — Newark Beth Israel Medical Center  
(*Newark Beth Israel Medical Center and AMNJ*)
- 16
- 23
- 30
- 2 **Clinical Hypnosis**
- 9 1-5 p.m. — Ramada Inn, Clark
- 16 (*Rutgers Medical School and AMNJ*)
- 2 **Internal Medicine and Therapeutics**
- 9 9-11 a.m. — Middlesex General Hospital,  
New Brunswick
- 16 (*Middlesex General Hospital and AMNJ*)
- 23
- 30
- 2 **New Non-Steroidal Anti-Inflammatory Drugs**
- 9 **To be announced**
- 16 **Environmental Cancer**
- 23 **Galactorrhea**
- 30 **Host Factors — Influencing the Impact of Disease**  
9:30-11:30 a.m. — Bergen Pines County Hospital  
(*Bergen Pines County Hospital and AMNJ*)
- 2 **Cardiology Conferences**
- 16 4-6 p.m. — Rutgers Medical School, Piscataway  
(*CMDNJ and AMNJ*)
- 2 **Continuing Medical Education Program**
- 9 10:30-11:30 a.m. — Clara Maass Memorial Hospital,  
Belleville
- 16 (*Clara Maass Memorial Hospital and AAFP*)
- 23
- 30
- 2 **Disease of the Renal Glomerulus**
- 9 **Interstitial Lung Diseases**
- 16 **Diabetes Insipidus**
- 23 **Acute and Chronic Hepatitis**
- 30 **Neurology of Old Age**  
9-11 a.m. — Riverview Hospital, Red Bank  
(*Riverview Hospital and AMNJ*)
- 2 **Psychiatry**
- 9 1-3 p.m. — Ancora Psychiatric Hospital, Hammonton
- 16 (*Ancora Psychiatric Hospital and AMNJ*)
- 30

- 2 **Courses for Psychiatrists**
  - 9 8-10 p.m. — Hackensack Hospital
  - 16 (New Jersey Psychoanalytic Society and AMNJ)
- 2 **CME Program for Family Practitioners**
  - 16 9-11 a.m. — West Jersey Hospital, Voorhees  
(West Jersey Hospital and AAFP)
- 3 **Pediatric Allergy Course**
  - 10 11 a.m.-12 noon — Children's Hospital of Newark
  - 17 (Children's Hospital of Newark and AMNJ)
  - 24
- 3 **Infectious Disease Course**
  - 8:30-9:30 a.m. — Somerset Hospital, Somerville  
(Somerset Hospital and AMNJ)
- 3 **Outpatient Management of Tuberculosis**
  - 11 a.m. — Greystone Park Psychiatric Hospital  
(AMNJ and AAFP)
- 3 **Acid Base Balance**
  - 10 **Heart Failure**
  - 17 **Ovarian Carcinoma**
    - 3:30-4:30 p.m. — Burlington County Memorial Hospital, Mount Holly  
(Burlington Co. Memorial Hospital)
- 4 **Laboratory Interpretations**
  - 8:30 a.m. — United Hospitals of Newark  
(AMNJ and AAFP)
- 4 **Gastrointestinal Hormone Assay**
  - 12 noon-1 p.m. — St. Mary's Hospital, Orange  
(St. Mary's Hospital and AMNJ)
- 4 **Psychiatric Lecture Series**
  - 18 1:30-5 p.m. — Trenton Psychiatric Hospital  
(Trenton Psychiatric Hospital and AMNJ)
- 5 **Symposium on Management of Colo-Rectal Carcinoma**
  - 9 a.m.-1 p.m. — North Jersey Country Club, Wayne  
(Greater Paterson General Hospital and AMNJ)
- 7 **Psychiatric Seminar**
  - 8-10 p.m. — 4 Garden Place, Nutley  
(Essex Psychiatric Seminar and AMNJ)
- 7 **Neuroscience Conferences**
  - 14 11:30 a.m.-12:30 p.m. — Bergen Pines County Hospital,
  - 21 Paramus
  - 28 (Bergen Pines County Hospital and AMNJ)
- 8 **Effect of Medications on Laboratory Tests**
  - 8 p.m. — Paul Kimball Hospital, Lakewood  
(AMNJ and AAFP)
- 8 **Medical Humanism: Hospital Ethics**
  - 12 noon — Hospital Center at Orange  
(AMNJ and AAFP)
- 9 **Echocardiography**
  - 1 p.m. — Christ Hospital, Jersey City  
(Christ Hospital)
- 9 **Cardiac Arrhythmias**
  - 1:30 p.m. — John E. Runnells Hospital, Berkeley Heights  
(AMNJ and AAFP)
- 9 **Acute Renal Failure**
  - 11:30 a.m. — Rahway Hospital  
(AMNJ and AAFP)
- 9 **Malpractice**
  - 3:15 p.m. — Fair Oaks Hospital  
(AMNJ and AAFP)
- 9 **Rapid Control of Violent Behavior**
  - 1:30-3:30 p.m. — Trenton Psychiatric Hospital  
(Trenton Psychiatric Hospital and AMNJ)
- 9 **Depression in Medical Diseases**
  - 7:30-9:30 p.m. — 159 Watchung Avenue, Montclair  
(Journal Club of Greater Newark and AMNJ)
- 12 **Family Therapy**
  - 9 a.m.-5 p.m. — Holiday Inn, Livingston  
(N.J. Center for Family Studies and AMNJ)
- 12 **Seminar in Anesthesiology**
  - 9 a.m.-3 p.m. — Rutgers Medical School, Piscataway  
(Educational Council for Anesthesiology of NJ and AMNJ)
- 13 **Pre-Hospital and ER Relationships**
  - 9:15 a.m.-4 p.m. — Holiday Inn, North Brunswick  
(Inter-Agency Commission on Emergency Medical Care and AMNJ)
- 15 **Northern Regional Chest Conferences**
  - 7:30-9:30 p.m. — Martland Hospital, Newark  
(New Jersey Thoracic Society and AMNJ)
- 15 **Diabetes**
  - 12 noon — St. Mary's Hospital, Orange  
(AMNJ and AAFP)
- 15 **Kidney Function and Anesthesia**
  - 8-9 p.m. — Ramada Inn, Clark  
(NJ State Society of Anesthesiologists and AMNJ)
- 16 **Significance of Adrenals in Hypertension**
  - 1-2 p.m. — VA Hospital, Lyons  
(VA Hospital and AMNJ)
- 16 **Special Problems in Neurology**
  - 7-10 p.m. — VA Hospital, East Orange  
(VA Hospital and AMNJ)
- 16 **Management of Acute Drug Abuse Emergencies**
  - 1 p.m. — Trenton Psychiatric Hospital  
(AMNJ and AAFP)
- 16 **Common Medical Problems for the Family Physician**
  - 8 a.m. — S. Ocean County Hospital, Manahawkin  
(Burlington County Memorial Hospital and AMNJ)
- 16 **Arthritis: New Agents**
  - 1 p.m. — Christ Hospital, Jersey City  
(Christ Hospital)
- 17 **Management of Cardiac Patients**
  - 6:15 p.m. — Bridgeton Hospital  
(Bridgeton Hospital)
- 17 **Sexual Incompatibility — Causes and Cures**
  - 5-6:30 p.m. — Somerset Hospital, Somerville  
(Somerset Hospital and AMNJ)



- 17 **Assertive Training**  
9:30 a.m.-3:30 p.m. — Trenton Psychiatric Hospital  
(*Trenton Psychiatric Hospital and AMNJ*)
  - 18 **Cardiac Rehabilitation**  
12 noon — Freehold Area Hospital  
(*AMNJ and AAFP*)
  - 23 **Headache**  
3:15 p.m. — Fair Oaks Hospital, Summit  
(*AMNJ and AAFP*)
  - 23 **Radiology**  
8-9 a.m. — So. Ocean County Hospital, Manahawkin  
(*Burlington County Memorial Hospital and AAFP*)
  - 25 **G.I. Bleeding**  
12:30 p.m. — Hamilton Hospital, Trenton  
(*AMNJ and AAFP*)
  - 28 **Intra-Aortic Balloon Pumping**  
8 p.m. — Warren Hospital, Phillipsburg  
(*AMNJ and AAFP*)
  - 29 **Clinical Pathological Conferences**  
1-2 p.m. — Trenton Psychiatric Hospital  
(*Trenton Psychiatric Hospital and AMNJ*)
  - 29 **The Psychiatrist in Community Mental Health Center**  
1:30-3:30 p.m. — Trenton Psychiatric Hospital  
(*Trenton Psychiatric Hospital and AMNJ*)
  - 30 **Hypertension II**  
1-3 p.m. — Christ Hospital, Jersey City  
(*Christ Hospital and AMNJ*)
  - 30 **Fall Refresher Course**  
9:15 a.m.-4:45 p.m. — John F. Kennedy Medical Center, Edison  
(*AAFP and AMNJ*)
  - 30 **Arthritis**  
3 p.m. — Ancora Psychiatric Hospital, Hammonton  
(*AMNJ and AAFP*)
  - 30 **Recent Advances in Myeloma**  
1-2 p.m. — VA Hospital, Lyons  
(*VA Hospital and AMNJ*)
  - 30 **EKG for the Practitioner**  
9-11 a.m. — West Jersey Hospital, Voorhees  
(*West Jersey Hospital and AAFP*)
- Dec.
- 1 **Pediatric Allergy Course**
  - 8 11 a.m.-12 noon — Children's Hospital of Newark
  - 15 (*Children's Hospital of Newark and AMNJ*)
  - 22
  - 1 **Infectious Disease Course**  
8:30-9:30 a.m. — Somerset Hospital, Somerville  
(*Somerset Hospital and AMNJ*)
  - 1 **Bleeding Diseases**  
11 a.m. — Greystone Park Psychiatric Hospital  
(*AMNJ and AAFP*)
- 1 **Inflammatory Bowel Disease**
  - 8 **Blood Transfusions**
  - 15 **Syphilis and the Clinician**  
3:30-4:30 p.m. — Burlington Co. Memorial Hospital, Mount Holly  
(*Burlington Co. Memorial Hospital*)
  - 1 **Pediatric Seminar**  
1-5 p.m. — Endocrinology Seminar  
8-9 p.m. — Ethical Problems in Pediatrics — Ramada Inn, Clark  
(*NJ Chapter, American Academy of Pediatrics and AMNJ*)
  - 2 **Psychiatric Lecture Series**
  - 9 1:30-5 p.m. — Trenton Psychiatric Hospital  
(*Trenton Psychiatric Hospital and AMNJ*)
  - 2 **Thanatology**  
8:30 a.m. — United Hospitals of Newark  
(*AMNJ and AAFP*)
  - 2 **Diabetes**  
12 noon — Freehold Area Hospital  
(*AMNJ and AAFP*)
  - 3 **Annual Meeting — American College of Surgeons**  
9 a.m.-4:30 p.m. — New Jersey Medical School, Newark  
(*American College of Surgeons and AMNJ*)
  - 5 **Neuroscience Conference**
  - 12 11:30 a.m.-12:30 p.m. — Bergen Pines County Hospital, Paramus  
(*Bergen Pines County Hospital and AMNJ*)
  - 5 **Bleeding Diseases**  
11 a.m. — Community Memorial Hospital, Toms River  
(*AMNJ and AAFP*)
  - 5 **Psychiatric Seminar**  
8-10 p.m. — 192 Chittenden Rd., Clifton  
(*Essex Psychiatric Seminar and AMNJ*)
  - 6 **Community Medicine**  
9:30-10:30 a.m. — Overlook Hospital, Summit  
(*Overlook Hospital and AAFP*)
  - 6 **Congenital Diseases**  
9 a.m. — Freehold Area Hospital  
(*AMNJ and AAFP*)
  - 6 **Continuing Education Lectures in Psychiatry**
  - 14 1-3 p.m. — Ancora Psychiatric Hospital, Hammonton  
(*Ancora Psychiatric Hospital and AMNJ*)
  - 7 **Pitfalls of Laboratory Screening**
  - 14 **Polycythemia Vera**
  - 21 **Aspirin for the Limping Brain**
  - 28 **Clinical Pathology Conference**  
9:30-11:30 a.m. — Bergen Pines County Hospital, Paramus  
(*AMNJ and AAFP*)
  - 7 **Cardiology Conferences**  
4-6 p.m. — Rutgers Medical School, Piscataway  
(*CMDNJ and AMNJ*)

- 7 **Cerebral Vascular Accident**  
3:15 p.m. — Fair Oaks Hospital, Summit  
(*AMNJ and AAFP*)
- 7 **New Methods of Endocrine Testing**  
1 p.m. — Christ Hospital, Jersey City  
(*AMNJ and AAFP*)
- 7 **Multidisciplinary Approach to Cancer**  
14 2-4 p.m. — Newark Beth Israel Medical Center  
21 (*Newark Beth Israel Medical Center and AMNJ*)  
28
- 7 **EKG for the Practitioner**  
14 9-11 a.m. — West Jersey Hospital, Voorhees  
21 (*West Jersey Hospital and AAFP*)  
28
- 7 **Cancer Chemotherapy Update**  
14 **Sex Therapy**  
28 **Traumatic Surgery and Shock**  
9-11 a.m. — Riverview Hospital, Red Bank  
(*Riverview Hospital and AMNJ*)
- 7 **Continuing Medical Education Program**  
10:30-11:30 a.m. — Clara Maass Memorial Hospital, Belleville  
(*Clara Maass Memorial Hospital and AAFP*)
- 7 **Peer Evaluation of Medical Care**  
7:30-9:30 p.m. — 377 So. Harrison St., East Orange  
(*Journal Club of Greater Newark and AMNJ*)
- 8 **Hard-to-Manage Diabetes**  
5-6:30 p.m. — Somerset Hospital, Somerville  
(*Somerset Hospital and AMNJ*)
- 9 **Hyperlipoproteinemia**  
11 a.m.-12:30 p.m. — Saddle Brook General Hospital  
(*Saddle Brook General Hospital and AMNJ*)
- 13 **Obesity and Hypoglycemia**  
8 p.m. — Paul Kimball Hospital  
(*AMNJ and AAFP*)
- 13 **Medical/Legal Aspects of Medicine and Surgery**  
9 p.m. — Bayonne Hospital  
(*AMNJ and AAFP*)
- 14 **Clinical E.E.G.**  
1 p.m. — Christ Hospital, Jersey City  
(*Christ Hospital*)
- 14 **Psychopharmacology**  
1:30-3:30 p.m. — Trenton Psychiatric Hospital  
(*Trenton Psychiatric Hospital and AMNJ*)
- 14 **Treatment and Prevention of Violence Among Youth**  
8:30-10:30 p.m. — Guido's Restaurant, Hackensack  
(*North Jersey Psychiatric Society and AMNJ*)
- 14 **Management of Hyperlipidemias**  
9 a.m.-4:30 p.m. — Rutgers Medical School, Piscataway  
(*CMDNJ, AMNJ and AAFP*)
- 15 **Endoscopy**  
6:15 p.m. — Bridgeton Hospital  
(*Bridgeton Hospital*)
- 16 **Management of Hepatitis**  
5 p.m. — Salem County Medical Society  
(*AMNJ and AAFP*)
- 19 **Surgical Management of Ulcerative Colitis**  
12 noon — Hospital Center at Orange  
(*AMNJ and AAFP*)
- 20 **Disseminated Intravascular Coagulation**  
12 noon — St. Mary's Hospital, Orange  
(*AMNJ and AAFP*)
- 21 **Common Medical Problems for the Family Physician**  
8 a.m. — S. Ocean County Hospital, Manahawkin  
(*Burlington County Memorial Hospital and AAFP*)
- 21 **Suicidology**  
3:15 p.m. — Fair Oaks Hospital, Summit  
(*AMNJ and AAFP*)
- 21 **Special Problems in Neurology**  
7-10 p.m. — VA Hospital, East Orange  
(*VA Hospital and AMNJ*)
- 27 **Clinical Pathological Conference**  
1-2 p.m. — Trenton Psychiatric Hospital  
(*Trenton Psychiatric Hospital and AMNJ*)
- 28 **Radiology**  
8-9 a.m. — So. Ocean County Hospital, Manahawkin  
(*Burlington County Memorial Hospital and AAFP*)
- 30 **Medical Care in Emergency Department**  
12:30 p.m. — Hamilton Hospital, Trenton  
(*AMNJ and AAFP*)
- Jan.  
2 **Medical Care in Emergency Department**  
8 p.m. — Community Memorial Hospital, Toms River  
(*AMNJ and AAFP*)
- 3 **Peripheral Vascular Disease**  
11 a.m. — Greystone Park Psychiatric Hospital  
(*AMNJ and AAFP*)
- 4 **Advances in Medicine**  
11 9:30-11 a.m. — Bergen Pines County Hospital, Paramus  
18 (*Bergen Pines County Hospital and AMNJ*)  
25
- 4 **Cardiology Conferences**  
18 4-6 p.m. — Rutgers Medical School, Piscataway  
(*CMDNJ and AMNJ*)
- 4 **New Developments in Scanning**  
3:15 p.m. — Fair Oaks Hospital, Summit  
(*AMNJ and AAFP*)
- 4 **Psychiatric Aspects of Endocrinology**  
1 p.m. — Christ Hospital, Jersey City  
(*AMNJ and AAFP*)
- 4 **Ultrasound and CAT Scanning**  
11 **Bronchial Asthma in Children**  
18 **Pulmonary Diseases**  
25 **Vascular Diseases and Vascular Occlusion**  
9-11 a.m. — Riverview Hospital, Red Bank  
(*Riverview Hospital and AMNJ*)

- 4 Psychiatry**  
**18** 1-3 p.m. — Ancora Psychiatric Hospital, Hammonton  
**25** (*Ancora Psychiatric Hospital and AMNJ*)
- 5 Pediatric Allergy Course**  
**12** 11 a.m.-12 noon — Children's Hospital of Newark  
**19** (*Children's Hospital of Newark and AMNJ*)  
**26**
- 5 Infectious Disease Course**  
 8:30-9:30 a.m. — Somerset Hospital, Somerville  
 (*Somerset Hospital and AMNJ*)
- 6 Outpatient Management of Tuberculosis**  
 8:30 a.m. — United Hospitals of Newark  
 (*AMNJ and AAFP*)
- 9 Neuroscience Conferences**  
**16** 11:30 a.m.-12:30 p.m. — Bergen Pines County Hospital,  
**23** Paramus  
**30** (*Bergen Pines County Hospital and AMNJ*)
- 10 Arthritis**  
 12 noon — Hospital Center at Orange  
 (*AMNJ and AAFP*)
- 10 Genetics**  
 8 p.m. — Paul Kimball Hospital, Lakewood  
 (*AMNJ and AAFP*)
- 11 Cerebral Vascular Disease**  
 11:30 a.m. — Rahway Hospital  
 (*AMNJ and AAFP*)
- 11 Fluid and Electrolyte Imbalance**  
 1:30 p.m. — John E. Runnells Hospital, Berkeley  
 Heights  
 (*AMNJ and AAFP*)
- 11 The Irritable Bowel Syndrome**  
 1-3:30 p.m. — VA Hospital, Lyons  
 (*VA Hospital and AMNJ*)
- 11 Ischemic Heart Disease**  
 1-3 p.m. — Christ Hospital, Jersey City  
 (*Christ Hospital, AMNJ and AAFP*)
- 15 Special Problems in Neurology**  
 7-10 p.m. — VA Hospital, East Orange  
 (*VA Hospital and AMNJ*)
- 15 Shock**  
 1-3 p.m. — Christ Hospital, Jersey City  
 (*Christ Hospital and AMNJ*)
- 17 Northern Regional Chest Conferences**  
 7:30-9:30 p.m. — Mountainside Hospital, Montclair  
 (*New Jersey Thoracic Society and AMNJ*)
- 17 Pulmonary Embolism**  
 12 noon — St. Mary's Hospital, Orange  
 (*AMNJ and AAFP*)
- 17 Role of Anesthesiologists in an Ambulatory Surgical Unit**  
 8-9 p.m. — Ramada Inn, Clark  
 (*NJ State Society of Anesthesiologists and AMNJ*)
- 18 Special Problems in Neurology**  
 7-10 p.m. — VA Hospital, East Orange  
 (*VA Hospital and AMNJ*)
- 18 Advanced Life Support in CPR**  
 1 p.m. — Trenton Psychiatric Hospital  
 (*AMNJ and AAFP*)
- 18 Medical Humanism-Hospital Ethics**  
 3:15 p.m. — Fair Oaks Hospital, Summit  
 (*AMNJ and AAFP*)
- 19 Cellular Engineering in Medicine**  
 5-6:30 p.m. — Somerset Hospital, Somerville  
 (*Somerset Hospital and AMNJ*)
- 19 Advances in Nephrology**  
 6:15 p.m. — Bridgeton Hospital  
 (*Bridgeton Hospital*)
- 24 Allergy**  
 8 p.m. — Warren Hospital, Phillipsburg  
 (*AMNJ and AAFP*)
- 25 Evaluation of Hemorrhagic and Bleeding Disorders**  
 1-2 p.m. — VA Hospital, Lyons  
 (*VA Hospital and AMNJ*)
- 27 Cardiac Arrhythmias**  
 12:30 p.m. — Hamilton Hospital, Trenton  
 (*AMNJ and AAFP*)
- Feb.**
- 1 Cardiology Conferences**  
**15** 4-6 p.m. — Rutgers Medical School, Piscataway  
 (*CMDNJ and AMNJ*)
- 1 Advances in Medicine**  
**8** 9:30-11 a.m. — Bergen Pines Hospital, Paramus  
**15** (*Bergen Pines County Hospital and AMNJ*)  
**22**
- 1 Cerebral Vascular Disease**  
 1 p.m. — Christ Hospital, Jersey City  
 (*AMNJ and AAFP*)
- 1 Total Joint Replacement and Bone Tumors**  
**8** **Lithium and Affective Disorders**  
**15** **Dermatologic Manifestations of Systemic Diseases**  
**22** **Infection in the Compromised Host**  
 9-11 a.m. — Riverview Hospital, Red Bank  
 (*Riverview Hospital, AMNJ and AAFP*)
- 1 Psychiatry**  
**7** 1-3 p.m. — Ancora Psychiatric Hospital, Hammonton  
**15** (*Ancora Psychiatric Hospital and AMNJ*)
- 2 Pediatric Allergy Course**  
**9** 11 a.m.-12 noon — Children's Hospital of Newark  
**16** (*Children's Hospital of Newark and AMNJ*)  
**23**
- 2 Infectious Disease Course**  
 8:30-9:30 a.m. — Somerset Hospital, Somerville  
 (*Somerset Hospital and AMNJ*)



- 2 **Diabetes**  
11 a.m. — Greystone Park Psychiatric Hospital  
(*AMNJ and AAFP*)
- 3 **Proper Uses of Blood Gases**  
8:30 a.m. — United Hospitals of Newark  
(*AMNJ and AAFP*)
- 6 **Neuroscience Conferences**
- 13 11:30 a.m.-12:30 p.m. — Bergen Pines County Hospital,  
20 Paramus  
27 (*Bergen Pines County Hospital and AMNJ*)
- 6 **Headache**  
8 p.m. — Community Memorial Hospital, Toms River  
(*AMNJ and AAFP*)
- 7 **Neonatal Emergencies**  
9 a.m. — Freehold Area Hospital  
(*AMNJ and AAFP*)
- 8 **Peripheral Vascular Disease**  
11:30 a.m. — Rahway Hospital  
1:30 p.m. — John E. Runnells Hospital, Berkeley  
Heights  
(*AMNJ and AAFP*)
- 11 **Seminar in Anesthesiology**  
9 a.m.-3 p.m. — New Jersey Medical School, Newark  
(*Educational Council for Anesthesiology of NJ and  
AMNJ*)
- 14 **Hyponitremia: Hypokalemia**  
8 p.m. — Paul Kimball Hospital, Lakewood  
(*AMNJ and AAFP*)
- 15 **Medical Humanism-Hospital Ethics**  
1 p.m. — Trenton Psychiatric Hospital  
(*AMNJ and AAFP*)
- 16 **Appropriate Workup for the Headache Patient**  
5-6:30 p.m. — Somerset Hospital, Somerville  
(*Somerset Hospital and AMNJ*)
- 16 **Problems in Biliary Tract Surgery**  
6:15 p.m. — Bridgeton Hospital  
(*Bridgeton Hospital*)
- 17 **Laboratory Interpretations**  
5 p.m. — Holiday Inn, Deepwater  
(*AMNJ and AAFP*)
- 17 **Endocrinology**  
12 noon — Freehold Area Hospital  
(*AMNJ and AAFP*)
- 20 **Current Surgical Techniques of Breast Cancer**  
12 noon — Hospital Center at Orange  
(*AMNJ and AAFP*)
- 20- **Endocrinology Symposium**
- 24 Nassau, Bahamas  
(*CMDNJ, AMNJ and VA Hospital, East Orange*)
- 21 **Northern Regional Chest Conferences**  
7:30-9:30 p.m. — St. Barnabas Hospital, Livingston  
(*New Jersey Thoracic Society and AMNJ*)
- 21 **Cancer of the Colon and Ovary**  
12 noon — St. Mary's Hospital, Orange  
(*AMNJ and AAFP*)
- 24 **Carcinoma of the Breast**  
12:30 p.m. — Hamilton Hospital, Trenton  
(*AMNJ and AAFP*)
- 28 **Drug Addiction**  
8 p.m. — Warren Hospital, Phillipsburg  
(*AMNJ and AAFP*)
- Mar.- 1 **Advances in Medicine**
- 8 9:30-11 a.m. — Bergen Pines County Hospital, Paramus  
15 (*Bergen Pines County Hospital and AMNJ*)  
22  
29
- 1 **Cardiology Conferences**
- 15 4-6 p.m. — Rutgers Medical School, Piscataway  
(*CMDNJ and AMNJ*)
- 1 **Proper Use of Blood Gases**  
11:30 a.m. — Rahway Hospital  
(*AMNJ and AAFP*)
- 1 **Fiberoptic Bronchoscopy**  
1 p.m. — Christ Hospital  
(*AMNJ and AAFP*)
- 1 **Courses for Psychiatrists**
- 8 8-10 p.m. — Hackensack Hospital  
15 (*NJ Psychoanalytic Society and AMNJ*)  
22  
29
- 1 **Immunology in Clinical Medicine**
- 8 **Controversies in Breast Cancer**
- 15 **Acupuncture**  
9-11 a.m. — Riverview Hospital, Red Bank  
(*Riverview Hospital, AMNJ and AAFP*)
- 1 **Psychiatry**
- 15 1-3 p.m. — Ancora Psychiatric Hospital  
20 (*Ancora Psychiatric Hospital and AMNJ*)  
29
- 2 **Pediatric Allergy Course**
- 9 11 a.m.-12 noon — Children's Hospital of Newark  
16 (*Children's Hospital of Newark and AMNJ*)  
23  
30
- 2 **Immunology**  
11 a.m. — Greystone Park Psychiatric Hospital  
(*AMNJ and AAFP*)
- 2 **Infectious Disease Course**  
8:30-9:30 a.m. — Somerset Hospital, Somerville  
(*Somerset Hospital and AAFP*)
- 3 **Clinical Immunology**  
8:30 a.m. — United Hospitals of Newark  
(*AMNJ and AAFP*)
- 3 **Psychiatric Lecture Series**
- 10 1:30-5 p.m. — Trenton Psychiatric Hospital  
17 (*Trenton Psychiatric Hospital and AMNJ*)
- 6 **Neuroscience Conferences**
- 13 11:30 a.m.-12:30 p.m. — Bergen Pines County Hospital,  
20 Paramus  
27 (*Bergen Pines County Hospital and AMNJ*)

- 6 Obstructive Lung Disease**  
8 p.m. — Community Memorial Hospital, Toms River  
(*AMNJ and AAFP*)
- 14 Cancer in New Jersey**  
8 p.m. — Paul Kimball Hospital, Lakewood  
(*AMNJ and AAFP*)
- 14 Medical Care in Emergency Department**  
9 p.m. — Bayonne Hospital  
(*AMNJ and AAFP*)
- 14 Medical/Legal Aspects of Medicine and Surgery**  
12 noon — Hospital Center at Orange  
(*AMNJ and AAFP*)
- 15 Special Problems in Neurology**  
7-10 p.m. — VA Hospital, East Orange  
(*VA Hospital and AMNJ*)
- 15 Diagnosis and Management of the Short Child**  
8:30-10 p.m. — 1257 Kensington Road, Teaneck  
(*Bergen Co. Chapter, American Medical Women's Assn. and AMNJ*)
- 15 Proper Use of Antibiotics**  
1 p.m. — Trenton Psychiatric Hospital  
(*AMNJ and AAFP*)
- 16 Sexual Counseling**  
6:15 p.m. — Bridgeton Hospital  
(*Bridgeton Hospital*)
- 16 Emotional Management in Myocardial Infarction**  
5-6:30 p.m. — Somerset Hospital, Somerville  
(*Somerset Hospital and AAFP*)
- 17 The Violent Patient**  
5 p.m. — Holiday Inn-Deepwater  
(*AMNJ and AAFP*)
- 17 Diagnosis of Anemic Patient**  
12 noon — Freehold Area Hospital  
(*AMNJ and AAFP*)
- Edward Waters Gynecologic Conference**  
17 2-7 p.m. }  
18 8:30 a.m.-7 p.m. } Resorts International  
19 9 a.m.-12:30 p.m. } Hotel, Atlantic City  
(*CMDNJ, NJ Medical School and AMNJ*)
- 21 Scanning**  
12 noon — St. Mary's Hospital, Orange  
(*AMNJ and AAFP*)
- 21 Congestive Heart Failure**  
8:30 p.m. — Fair Lawn Memorial Hospital — Marriott, Saddlebrook  
(*AMNJ and AAFP*)
- 21 Northern Regional Chest Conferences**  
7:30-9:30 p.m. — St. Joseph's Hospital, Paterson  
(*New Jersey Thoracic Society and AMNJ*)
- 24 Bleeding Disorders**  
12:30 p.m. — Hamilton Hospital, Trenton  
(*AMNJ and AAFP*)
- 28 Hepatitis**  
8 p.m. — Warren Hospital, Phillipsburg  
(*AMNJ and AAFP*)
- 29 Cerebral Vascular Disease**  
3 p.m. — Ancora Psychiatric Hospital, Hammonton  
(*AMNJ and AAFP*)
- Apr.**
- 3 Neuroscience Conferences**  
10 11:30 a.m.-12:30 p.m. — Bergen Pines County Hospital,  
17 Paramus  
24 (*Bergen Pines County Hospital and AMNJ*)
- 3 Suicidology**  
8 p.m. — Community Memorial Hospital, Toms River  
(*AMNJ and AAFP*)
- 4 New Developments in Scanning**  
11 a.m. — Greystone Park Psychiatric Hospital  
(*AMNJ and AAFP*)
- 5 Advances in Medicine**  
12 9:30-11 a.m. — Bergen Pines County Hospital, Paramus  
19 (*Bergen Pines County Hospital and AMNJ*)  
26
- 5 Cardiology Conferences**  
19 4-6 p.m. — Rutgers Medical School, Piscataway  
(*CMDNJ and AMNJ*)
- 5 Outpatient Management of Tuberculosis**  
11:30 a.m. — Rahway Hospital  
(*AMNJ and AAFP*)
- 5 Suicidology**  
1 p.m. — Christ Hospital, Jersey City  
(*AMNJ and AAFP*)
- 5 Courses for Psychiatrists**  
12 8-10 p.m. — Hackensack Hospital  
19 (*NJ Psychoanalytic Society and AMNJ*)  
26
- 6 Pediatric Allergy Course**  
13 11 a.m.-12 noon — Children's Hospital of Newark  
20 (*Children's Hospital of Newark and AMNJ*)  
27
- 6 Infectious Disease Course**  
8:30-9:30 a.m. — Somerset Hospital, Somerville  
(*Somerset Hospital and AMNJ*)
- 7 Infectious Diseases**  
8:30 a.m. — United Hospitals of Newark  
(*AMNJ and AAFP*)
- 7 Psychiatric Lecture Series**  
14 1:30-5 p.m. — Trenton Psychiatric Hospital  
21 (*Trenton Psychiatric Hospital and AMNJ*)  
28
- 8 Third Annual Orthopedic Symposium**  
Rutgers Medical School, Piscataway  
(*AMNJ and AAFP*)

- 11 **Fluid and Electrolyte Balance**  
12 noon—Hospital Center at Orange  
(*AMNJ and AAFP*)
  - 12 **Proper Use of Blood Gases**  
1:30 p.m.—John E. Runnells Hospital, Berkeley Heights  
(*AMNJ and AAFP*)
  - 12 **Psychiatry**  
17 1-3 p.m.—Ancora Psychiatric Hospital, Hammonton  
19 (*Ancora Psychiatric Hospital and AMNJ*)  
26
  - 18 **Northern Regional Chest Conferences**  
7:30-9:30 p.m.—Location to be announced  
(*New Jersey Thoracic Society and AMNJ*)
  - 18 **Intra-Aortic Balloon Pumping**  
12 noon—St. Mary's Hospital, Orange  
(*AMNJ and AAFP*)
  - 19 **The Psychodynamics of Dental Practice**  
9 a.m.-4 p.m.—New Jersey Dental School, Newark  
(*AMNJ and CMDNJ*)
  - 19 **Special Problems in Neurology**  
7-10 p.m.—VA Hospital, East Orange  
(*VA Hospital and AMNJ*)
  - 20 **Nevi and Melanoma**  
6:15 p.m.—Bridgeton Hospital  
(*Bridgeton Hospital*)
  - 21 **Management of Hepatitis**  
12 noon—Freehold Area Hospital  
(*AMNJ and AAFP*)
  - 22 **Seminar in Anesthesiology**  
9 a.m.-3 p.m.—Saint Barnabas Medical Center, Livingston  
(*Educational Council for Anesthesiology of NJ and AMNJ*)
  - 25 **Medical/Legal Aspects of Medicine and Surgery**  
8 p.m.—Warren Hospital, Phillipsburg  
(*AMNJ and AAFP*)
  - 28 **Surgical Management of Inflammatory Bowel Disease**  
12:30 p.m.—Hamilton Hospital, Trenton  
(*AMNJ and AAFP*)
- May**
- 1 **Neuroscience Conferences**  
8 11:30 a.m.-12:30 p.m.—Bergen Pines County Hospital,  
15 Paramus  
22 (*Bergen Pines County Hospital and AMNJ*)
  - 1 **Arthritis**  
8 p.m.—Community Memorial Hospital, Toms River  
(*AMNJ and AAFP*)
  - 1 **Psychiatry**  
17 1-3 p.m.—Ancora Psychiatric Hospital, Hammonton  
30 (*Ancora Psychiatric Hospital and AMNJ*)
  - 2 **Thyroid Disease**  
11 a.m.—Greystone Park Psychiatric Hospital  
(*AMNJ and AAFP*)
  - 3 **Advances in Medicine**  
10 9:30-11 a.m.—Bergen Pines County Hospital,  
17 Paramus  
24 (*Bergen Pines County Hospital and AMNJ*)
  - 3 **Cardiology Conferences**  
17 4-6 p.m.—Rutgers Medical School  
(*CMDNJ and AMNJ*)
  - 3 **Medical Humanism-Hospital Ethics**  
11:30 a.m.—Rahway Hospital  
(*AMNJ and AAFP*)
  - 3 **Courses for Psychiatrists**  
8-10 p.m.—Hackensack Hospital  
(*NJ Psychoanalytic Society and AMNJ*)
  - 4 **Pediatric Allergy Course**  
11 11 a.m.-12 noon—Children's Hospital of Newark  
18 (*Children's Hospital of Newark and AMNJ*)  
25
  - 4 **Infectious Diseases Course**  
8:30-9:30 a.m.—Somerset Hospital, Somerville  
(*Somerset Hospital of Newark and AMNJ*)
  - 5 **Cerebral Vascular Disease**  
8:30 a.m.—United Hospitals of Newark  
(*AMNJ and AAFP*)
  - 6- **MSNJ Annual Meeting**  
9 Holiday Inn-Howard Johnson's Regency, Atlantic City
  - 9 **Fluid and Electrolyte Imbalance**  
9 p.m.—Bayonne Hospital  
(*AMNJ and AAFP*)
  - 10 **Arthritis**  
1:30 p.m.—John E. Runnells Hospital, Berkeley Heights  
(*AMNJ and AAFP*)
  - 15 **Endotoxic/Hemorrhagic Shock**  
12 noon—Hospital Center at Orange  
(*AMNJ and AAFP*)
  - 16 **Kidney Stones**  
12 noon—St. Mary's Orange  
(*AMNJ and AAFP*)
  - 17 **Special Problems in Neurology**  
7-10 p.m.—VA Hospital, East Orange  
(*VA Hospital and AMNJ*)
  - 18 **Advances in Pediatrics**  
6:15 p.m.—Bridgeton Hospital  
(*Bridgeton Hospital*)
  - 18 **Antithrombotic Therapy**  
5-6:30 p.m.—Somerset Hospital, Somerville  
(*Somerset Hospital and AMNJ*)
  - 19 **Chronic Renal Failure**  
12 noon—Freehold Area Hospital  
(*AMNJ and AAFP*)
  - 23 **Common Topical Agents in Dermatological Practice**  
8:30-10 p.m.—645 Cambridge Road, Paramus  
(*Bergen Co. Chapter, American Medical Women's Association and AMNJ*)



- 23 Cerebral Vascular Disease**  
8 p.m. — Warren Hospital, Phillipsburg  
(*AMNJ and AAFP*)
- 26 Ophthalmologic Manifestations in Systemic Disease**  
12:30 p.m. — Hamilton Hospital, Trenton  
(*AMNJ and AAFP*)
- 31 Cardiac Arrhythmias**  
3 p.m. — Ancora Psychiatric Hospital, Hammonton  
(*AMNJ and AAFP*)
- June**
- 1 Infectious Disease Course**  
8:30-9:30 a.m. — Somerset Hospital, Somerville  
(*Somerset Hospital and AAFP*)
- 1 Current Radiation Therapy**  
11 a.m. — Greystone Park Psychiatric Hospital  
(*AMNJ and AAFP*)
- 2 Lipid Metabolism**  
8:30 a.m. — United Hospitals of Newark  
(*AMNJ and AAFP*)
- 5 Neuroscience Conferences**  
**12** 11:30 a.m.-12:30 p.m. — Bergen Pines County Hospital,  
**19** Paramus  
**26** (*Bergen Pines County Hospital and AMNJ*)
- 5 Thyroid Diseases**  
8 p.m. — Community Memorial Hospital, Toms River  
(*AMNJ and AAFP*)
- 7 Advances in Medicine**  
**14** 9:30-11 a.m. — Bergen Pines County Hospital, Paramus  
(*Bergen Pines County Hospital and AMNJ*)
- 7 Cardiology Conferences**  
**21** 4-6 p.m. — Rutgers Medical School, Piscataway  
(*CMDNJ and AMNJ*)
- 7 Psychiatry**  
**14** 1-3 p.m. — Ancora Psychiatric Hospital, Hammonton  
(*Ancora Psychiatric Hospital and AMNJ*)
- 15 Beta-Adrenergic Blocking Agent in Cardiovascular Disease**  
5-6:30 p.m. — Somerset Hospital, Somerville  
(*Somerset Hospital and AMNJ*)
- 16 Sports Medicine**  
12 noon — Freehold Area Hospital  
(*AMNJ and AAFP*)
- 20 Northern Regional Chest Conferences**  
7:30-9:30 p.m. — Beth Israel Hospital, Newark  
(*New Jersey Thoracic Society and AMNJ*)
- 20 Acute and Chronic Leukemia**  
12 noon — St. Mary's Hospital, Orange  
(*AMNJ and AAFP*)
- 20 Shock**  
8:30 p.m. — Fair Lawn Memorial Hospital — Marriott,  
Saddle Brook  
(*AMNJ and AAFP*)
- 21 Special Problems in Neurology**  
7-10 p.m. — VA Hospital, East Orange  
(*VA Hospital and AMNJ*)
- 27 Current Radiation Therapy**  
8 p.m. — Warren Hospital, Phillipsburg  
(*AMNJ and AAFP*)

## OBITUARIES

### Dr. Braulio L. Borlaza

At the untimely age of 48, Braulio L. Borlaza, M.D., died on August 22 after a lengthy illness. A native of the Philippines where he earned his medical degree in 1957 from the College of Medicine of the University of Santo Tomas, Dr. Borlaza came to New Jersey in 1960 to intern at the Perth Amboy General Hospital and went on to take residencies in internal medicine and neurology at Goldwater Memorial Hospital in New York. He briefly had worked at Trenton and Marlboro Psychiatric Hospitals before establishing a private practice in 1968 in Englishtown, which he maintained until illness forced his inactive status in early 1976. Dr. Borlaza was a member of the Monmouth County Medical Society and on the staff at

Marlboro Psychiatric Hospital and the Freehold Area Hospital.

### Dr. Sigmund C. Braunstein

One of Hudson County's senior members, Sigmund C. Braunstein, M.D., died at his home on July 9 after a long illness. Born just before the turn of the century (1898), Dr. Braunstein was graduated from Tufts Medical College, class of 1922, and practiced general medicine in West New York until illness forced his retirement in 1975. He had been on the staff at North Hudson Hospital in Weehawken and Christ Hospital in Jersey City, and had served his home community as medical director for the schools of West New York. Dr. Braunstein was active in medical society affairs and had served a term as president of his county medical society. In 1972 he was a recipient of MSNJ's Golden Merit Award indicating fifty years of medical practice.

### **Dr. Filarginio DePasquale**

Word has just been received of the death on July 11 in Columbus Hospital, Newark, of Filarginio DePasquale, M.D. of Newark. Born in Italy in 1899 and graduated from the Royal University of Naples College of Medicine in 1926, Dr. DePasquale emigrated to the United States at the end of World War II and after licensure in 1947 established a general practice in Jersey City. He subsequently opened another office in Newark and maintained both until retirement in 1975. He was a member of the Hudson County Medical Society and had been associated with the Margaret Hague Hospital in Jersey City.

### **Dr. John H. Jentz**

John H. Jentz, M.D., a member of our Hudson County component, died on August 1 at Cape Cod Hospital, Hyannis, Massachusetts, where he had been living in retirement. Born in Jersey City at the turn of the century and graduated from New York Medical College in 1923, Dr. Jentz practiced obstetrics in his home town until illness forced retirement in 1962. He had been on the attending staff at Christ Hospital, Jersey City.

### **Dr. John E. Longnecker, Jr.**

Word has just been received of the death on July 22, after a long illness, of John E. Longnecker, Jr., M.D., a member of our Sussex County Medical Society. Born in 1906 and graduated from the medical school at Western Reserve University, class of 1932, Dr. Longnecker practiced general medicine in Sparta for many years, retiring in 1972. He had been associated with Newton Memorial Hospital, Newton and Alexander Linn Hospital, Sussex.

### **Dr. Edward G. Osborn**

A well-known Camden County surgeon, Edward G. Osborn, M.D., formerly chief of surgery at Our Lady of Lourdes Hospital, Camden, died of a heart ailment on August 5 at the hospital. Born in 1913 and graduated from Jefferson Medical College in 1940, Dr. Osborn took a residency in surgery at the University of Pennsylvania Graduate School of

Medicine and became board certified in that specialty. He was a Fellow of the American College of Surgeons and a member of the New Jersey Society of Surgeons. In addition to Our Lady of Lourdes, he had been affiliated with the Cooper Medical Center and the Ancora State Hospital in the departments of surgery. He was active in medical society affairs, having served a term as president of the Camden County Medical Society. Upon retirement in 1975, Dr. Osborn donated his medical facility to Our Lady of Lourdes Hospital for use as a family health center and it bears his name. During World War II, he served for three years in the medical department of the Army of the United States in Africa and Italy.

### **Dr. Ahmet Samedov**

On July 29, in Newcomb Hospital, Vineland, Ahmet Samedov, M.D., died of a heart ailment. A native of Russia, Dr. Samedov earned his medical degree from the Askabad Medical Institute (Russia) in 1937. He pursued graduate work in psychiatry and emigrated to the United States in the early 1950's. He had been a full-time staff member at the Ancora State Hospital until establishing private practice in Vineland in 1959. Dr. Samedov had been associated with the Vineland State School, the Newcomb Hospital in Vineland, and the Salem Memorial Hospital in Salem. He was a member of the American and New Jersey Psychiatric Associations. Dr. Samedov was 64 years old at the time of his death.

### **Dr. Jacob W. Siegel**

One of Essex County's senior members, Jacob W. Siegel, M.D., died at his home on August 20. Born in 1892 and graduated from New York University Medical School, class of 1915, Dr. Siegel was a general surgeon with special interest in industrial medicine. He was a Fellow of the American College of Surgeons and had been attending surgeon at Presbyterian Hospital, Newark and St. Barnabas Medical Center, Livingston, and was the medical director for Crucible Steel Company in Harrison. Formerly from Newark, Dr. Siegel retired in 1967 and moved to Madison. He was the father of Dr. Robert Siegel, a surgeon from Scotch Plains, who died in 1969.

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the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

**Usual Daily Dosage:** Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. *Geriatric patients:* 5 mg b.i.d. to q.i.d. (See Precautions.)

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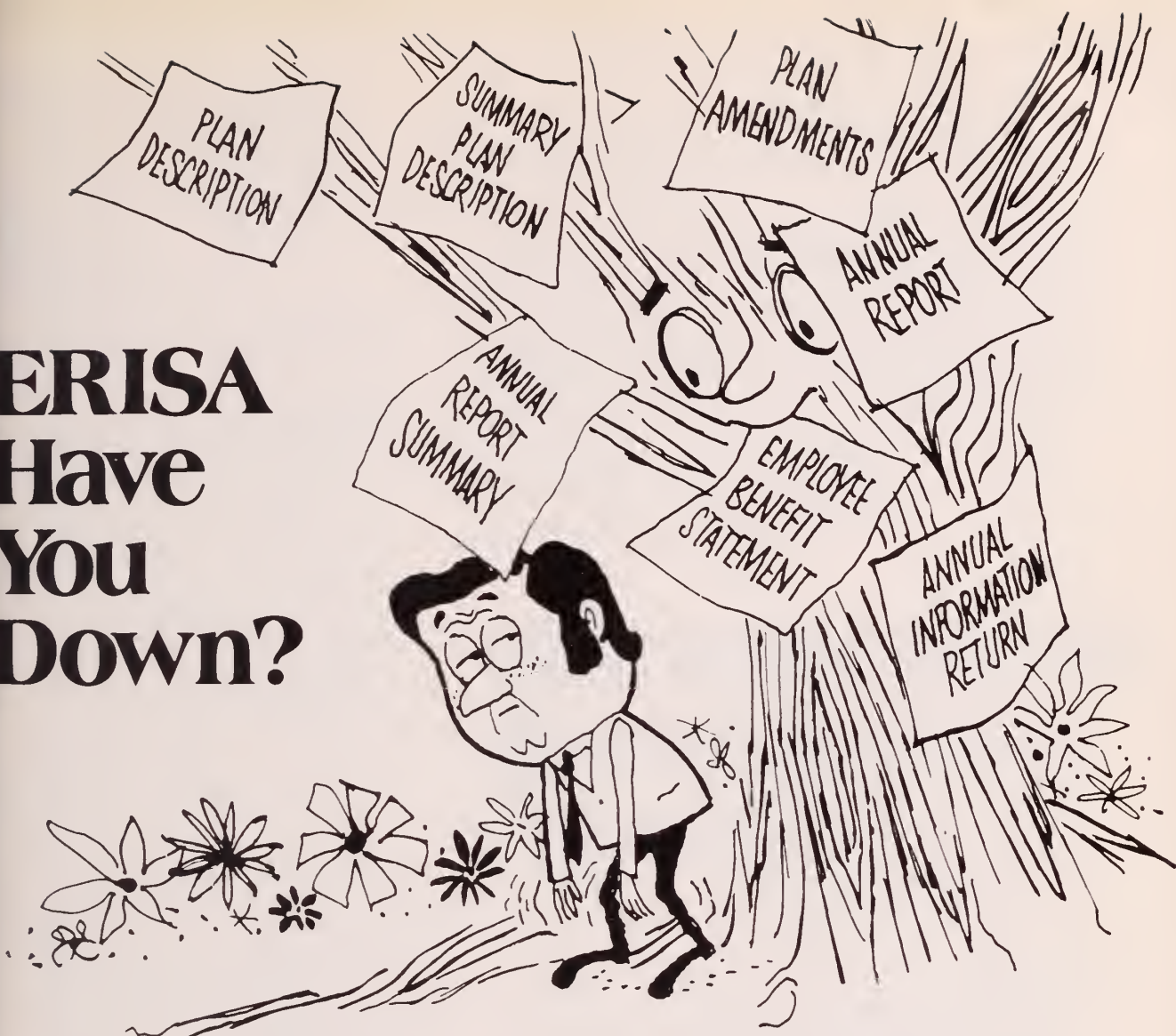
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# Blue Shield to drop 28 plan procedures

CHICAGO (Reuters) — The Blue Shield Association, the nation's largest health insurance group, yesterday said it was ending routine coverage for a variety of medical procedures deemed largely unnecessary.

Included in Blue Shield's new Medical Necessity Program (MNP) are 18 surgical and 10 diagnostic procedures which together cost the company more than \$27 million in 1975.

Blue Shield, which reimburses physicians for care provided to some 46 million persons covered by Blue Shield, will pay for such procedures only if the performing physician can justify them in writing.

William Ryan, Blue Shield president, told a press conference MNP was aimed at helping stem the rising cost of health care and saving money for Blue Shield subscribers.

A Blue Shield spokesman said subscribers could not expect lower premiums or rebates, but the rate of increase in premiums might be slowed by MNP.

Ryan said that in setting up the MNP, Blue Shield was assisted by the American College of Physicians, the American College of Radiology, and the American College of Surgeons.

He said the 28 procedures either were of questionable value, were redundant when performed along with other procedures, or were unlikely to provide additional information when performed more than once.

However, he told newsmen "If there is a clear need for any of the procedures, Blue Shield will pay for them. The point of this program is to encourage medical professionals to think about the costs of the procedures they order."

The MNP also covers two surgical procedures for which Blue Shield has never paid claims, and will be expanded to cover other procedures after further study, Ryan said.

The plan will go into effect after it has been explained to physicians and subscribers over the next several months.

A spokesman for New Jersey Blue Shield said the state plan had been researching a similar program just for New Jersey, but she did not have figures on how many such procedures are done in this state each year.

The techniques include surgical and diagnostic tests which are no longer considered of any value or have been replaced by better methods. Others are procedures which have no proven worth, and diagnostic tests which yield little new information.

Examples, she said, are surgery on the carotid artery in the neck as treatment for asthma and surgery on certain sympathetic nerves as a treatment for high blood pressure.

Two diagnostic tests once fairly common, the basal metabolism rate (BMR), a test for an overactive thyroid gland, and the protein bound iodine test to measure circulating thyroid hormones, also are on the no payment list.

She said New Jersey Blue Shield plans an extensive communications campaign to educate physicians about the program, and then will set a cutoff date after which physicians will need prior authorization to get paid for any of the 28 procedures.

A local physician review panel will be set up to settle any disputes.

## Blue Shield Plans to Curtail Payments For Procedures Considered Ineffective

By WALL STREET JOURNAL Staff Reporter

CHICAGO — Blue Shield intends to discourage physicians from performing what are deemed obsolete or ineffective operations and diagnostic tests as a way to check runaway medical costs.

At least one of the nation's 72 million Blue Shield subscribers, \$27.4 million annually, has been out of favor among surgeons for 50 years.

The so-called Medical Necessity Program was announced at a press conference here yesterday by Blue Shield Association, a trade group, and representatives from three medical specialty groups: Paralel with Blue Cross, which provides hospitalization insurance, the 10 U.S. Blue Shield plans spend more than \$7 billion a year reimbursing doctors for medical and surgical care.

Blue Shield won't pay doctors for any of the 28 procedures unless they justify their need in writing, explained William E. Ryan, Blue Shield Association president. He noted that not all of the \$27.4 million will be saved and passed on to subscribers in the form of smaller rate increases.

But the savings will be substantial, Mr. Ryan said. And this first step to identify and eliminate unnecessary procedures

could become one of the most effective ways to limit future increases in health care expenditures.

The 28 procedures involve 18 types of surgery for such ailments as hemorrhoids, asthma, lower back pain and high blood pressure. Ten diagnostic tests on Blue Shield's no-payment list include ones for jaundice, overactive thyroid glands and limited heart X-rays.

To devise the program, the Blue Shield Association studied the medical records of its 75 million federal employee subscribers. The group found, for instance, that it pays about \$3.9 million a year for urologic suspension operations. This kind of surgery, performed to relieve lower back pain, "was formed to relieve lower back pain," said C. Rollins Hanlon, director of the American College of Surgeons.

The problem with two of the diagnostic procedures, all involving heart X-rays, is that they were said to provide a picture from only one perspective. With such an approach, "you're going to miss the diagnosis," said Dr. Richard Alyn, a regent for the American College of Physicians. Other diagnostic tests on the list represent "primarily tired techniques that are being

retired," said Dr. Fredric D. Lake, president of the American College of Radiology.

Some reporters questioned the Blue Shield and medical officials as to why their list omits new procedures with unproven effectiveness, such as coronary bypass surgery and CAT scanning. A form of computerized X-rays. Because they're "too controversial," replied Dr. Alyn. "Too controversial" acceptance we had to first take the ones that are generally recognized as outmoded," Mr. Ryan said.

But the Blue Shield executive emphasized that the no-payment list is "by no means exhaustive," and that it will be expanded to cover new procedures with undemonstrated effectiveness as well as other medical specialties. Mr. Ryan estimated that it would take several months for the 70 Blue Shield plans to inform and educate their local physicians that they intend to discontinue routine payment for the 28 procedures.

Another reporter asked if the Blue Shield effort was designed to head off President Carter's proposed 9% ceiling on most hospital revenue increases next year. Mr. Ryan said Blue Shield might show Mr. Ryan could "control health costs" than government.

## Blue Shield Acts to Curb Payment On Procedures of Doubtful Value

By JANE E. BRODY

The national Blue Shield Association announced yesterday that its individual plans also stop routine payments for surgical and diagnostic procedures considered outmoded or unnecessary but that currently cost subscribers \$27.4 million a year.

The list of procedures, which includes the basal metabolic rate, extensive surgery for hemorrhoids and removal of the clitoral hood, was compiled in consultation with leading medical specialty organizations to assure that all procedures done on Blue Shield subscribers are "medically necessary," a Blue Shield spokesman said.

In eliminating certain procedures from reimbursement, the nation's largest health insurance carrier feels that it will in effect rapidly upgrade the quality of medical care in many parts of the country.

The new payment schedules will be adopted in whole or in part by Blue Shield plans throughout the country after local physicians are informed to decide whether to accept the recommended changes. The new schedules will apply to all present and future Blue Shield contracts.

As a result of physician education, the changes are expected to spill over to non-subscribers, who last year paid \$58 million for these procedures.

In addition, Blue Cross plans are studying the Blue Shield proposals and meeting with hospitals and other medical care providers to work out a similar revised payment schedule, a Blue Cross spokesman said. He added that some plans might retain routine payments for procedures on the Blue Shield list, explaining that "some of these procedures are not considered unnecessary in certain parts of the country."

The Blue Shield list was devised in consultation with the American College of Surgeons, the American College of Radiology, the American College of Physicians, and the American Hospital Association. The American Hospital Association was also involved.

Blue Shield said that the procedures on the list were either new and of unproven value, established but of questionable value, or redundant, unnecessary, or unlikely to give the other procedures additional information.

"If a procedure is outmoded, it means there are better procedures available with better outcomes," the Blue Shield spokesman said. "We want to make sure that the most effective procedure is performed," which would increase the benefit-to-risk ratio.

The organization said that once the new schedules took effect, patients would be reimbursed for a listed procedure only if their doctors submitted written justification. The documentation would have to be approved by a review panel of physicians provided by a review panel of physicians.

The spokesman said that if the revision of payment schedules was to accord with the Blue Shield contract, which states that the organization will not pay for procedures that are not medically necessary.

The surgical procedures on the Blue Shield list are as follows: Removal of interrupting portions of the sympathetic nerves in the back to treat hypertension; radical surgery to remove hemorrhoids; fixation or suspension of a floating kidney; tying of the mammary arteries in the chest.

Also, fastening a tissue from the stomach to other organs to establish better blood flow through the liver; surgical removal of a fatty or fibrous structure covering the kidney; injecting the adrenal glands for X-rays of the female kidneys for the diagnosis of the female glands; circumcision of the uterus through removal of the hood of the uterus through hysterectomy; cutting into the cervix; removal of the uterus but not the cervix; removing or suspending the uterus to the vagina or abdominal wall with or without interruption of the nerve pathways in one area.

Also, removal of part of the hypogastric or presacral nerve; two methods of relieving the weakness of connective tissue binding body structures; and tying the femoral artery for postoperative syndrome.

The diagnostic procedures listed are: Basal metabolic rate and protein bound iodine tests; the presence of jaundice, the balance test; a measure of the amount of blood in the heart; the phonocardiogram, a test of various heart sounds; a diagram, a test of various heart sounds; four types of angiograms (X-rays) of the heart, and angiography of the arteries of the arms and legs to determine the presence of clots, ruptures or arterial constrictions.

The new procedures listed were fabric wrapping of an abdominal aneurysm and extra-intracranial arterial bypass for stroke.

# What is Blue Shield's Medical Necessity Program?

It's a program worked out with the American College of Physicians, the American College of Radiology, the American College of Surgeons, and other medical associations to improve the quality of medical care and possibly aid in cost containment. This will be accomplished through ending routine Blue Shield payment for 18 surgical and 10 diagnostic procedures, which are seldom performed, unless the physician can justify their use.



## Blue Shield of New Jersey



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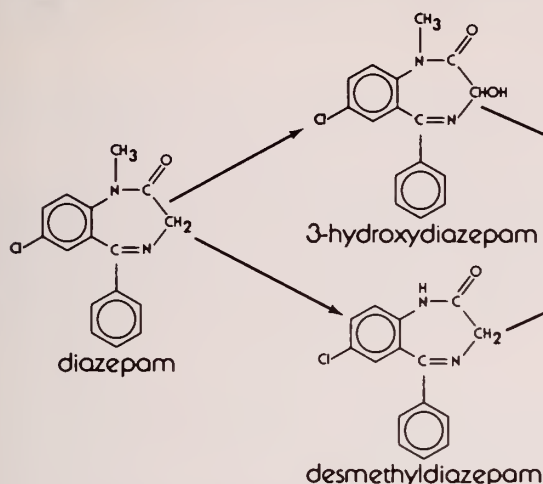
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**Usage in Pregnancy:** Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

**Precautions:** If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

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today, 94 to 0, and sent to

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The Social Security Bill,  
a broad program of unem  
insurance and old age  
and counted upon to be  
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day when it was signed  
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safety to create it.'

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trayal."

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gave their lives in the first World  
War, in which he himself served,  
seemed to give unconscious expres-  
sion to the solemn feeling of the  
occasion when, at the outset of his  
speech, he interpolated the words,  
half a hope, half a prayer:

"Oh, what a great day this can  
be in history!"

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Paris today, and after re-  
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*The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely-prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.*

*The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.*

## **The Advantages**

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

Every doctor has had patients who fail to finish antibiotic regimens because they feel better. Some patients assume that if one tranquilizer or analgesic is good, two may be twice as good. Still others fail to report dizziness while on antihypertensive therapy—and so on.

Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

## **The Disadvantages**

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information

is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

## **The Solution**

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.

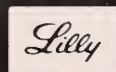
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# EDITORIALS

## Ambulance Service 1909-1977

Our cover picture tells the story of medical progress over the past seventy years more eloquently than one could with the traditional "thousand words." According to the authorities of the Helene Fuld Medical Center, Trenton (formerly McKinley Hospital), the ambulance driver was the hospital administrator and the intern and nurse are not identified. The Lifemobile of Mercer County, also administratively headquartered in the same institution, is staffed by a trained driver, a paramedic, and a nurse.

The costs of the two ambulances are striking. It is estimated that the horse and wagon cost less than \$100 at that time (although the Smithsonian Information Center was unable to give us an exact figure). The basic cost for an ambulance such as the Lifemobile varies from \$20,000 to \$40,000, depending on the degree of sophistication, while the equipment for advanced life support is about \$15,000 additional.

While government officials, politicians, and journalists continue to rant and rave at the costs of medical care in the second half of the twentieth century, one must shake his head in "wonderment." Which Congressman would choose the horse and wagon to rattle through the streets of Washington to deliver him to a hospital, should he have a coronary occlusion? Would he want a hospital administrator in attendance or a trained paramedic and intensive care nurse? Would he prefer his vital signs to be monitored from the floor of the halls of Congress and antiarrhythmic drugs administered on the spot—or hope the horse didn't have to stop to answer the call of nature enroute to the closest hospital. Would he select telemetering of vital signs via electronic devices—an expensive tool—or extrasensory perception, which is free?

Modern health care costs money. It is expen-

sive to train paramedics and I.C.U. nurses, trauma surgeons, and emergency department personnel. Equipment of modern vintage is costly. Helicopters and Lifemobiles don't grow on trees.

Most of all, the government officials should not take too much credit for the Lifemobile program for it was a community project with major contributions by the American Heart Association, the area rescue squads, industry and the business world, interested individuals and civic and community groups, physicians, nurses, and hospital administrators.

The American health care system works because a lot of people outside of government participate. Let's keep it that way! A.K.

## Life Month

November is the twentieth "Life Month" for our original Life Plan with the Nationwide Life Insurance Company. Over \$3,200,000 has been paid to beneficiaries under this plan. Since each unit of insurance provides \$10,000 of death protection with double indemnity in case of accidental death, as well as a guaranteed conversion provision and a waiver of premium provision without extra charge, this represents over 320 units of insurance that have provided funds to beneficiaries.

Inflation has made increased insurance protection a necessity. Our low-cost, non-cancelable plan makes it easier for members to provide adequately for their families, especially since issuance has been simplified and in many cases applicants no longer need physical examinations.

A special "Life Month" mailing is being sent this month by our administrator, who will be happy to provide help and information as to the best uses of the total program for your circumstances. Look for your application in the mail. David Blanksteen



# Laughing Gas No Laughing Matter

While visiting London recently, your editor was chagrined to read about an unfortunate lady, Elizabeth Shewan, whose brain was irreparably damaged by the inadvertent administration of nitrous oxide instead of oxygen. After a review of the case, a British Area Health Authority committee exonerated the doctors involved and labeled the mishap an unfortunate accident. It seems the hoses carrying the gases were not color-coded, the connectors were interchangeable, and there were no other fail-safe techniques.

My American smugness, which believed that this never could happen here, was dispelled immediately by the case at the Southmore Medical Center, Pasadena, Texas. This was followed soon thereafter by the Suburban General Hospital, Norristown, Pennsylvania report. In the Texas case, Carolyn Ann Lord died in 1974 after delivery of a living child when she was given nitrous oxide instead of oxygen. Investigation disclosed that the plumbing contractor who installed the internal oxygen, nitrous oxide, air, and vacuum pipeline systems in the hospital crossed the gas pipes so that oxygen flowed into the line marked nitrous oxide and nitrous oxide flowed into the line marked oxygen. A jury did not find this a laughing matter and awarded seven million dollars in damages to the family of Mrs. Lord.

The Norristown, Pennsylvania case may have been worse in terms of the potential number of patients involved over a six-month period in the Suburban General Hospital's emergency room. The problem was said to be the same, i.e., a built-in gas system with oxygen being fed into outlets labeled nitrous oxide and nitrous oxide into outlets labeled oxygen.

What are the precautions that normally are considered protective? Inspection of one hospital disclosed the following:

1. Storage nitrous oxide tanks are color-coded and kept in a separate room from oxygen storage tanks, which also are color-coded.

2. The hoses in the operating room carrying nitrous oxide and oxygen are color-coded.

3. The small (portable) cylinders of nitrous oxide and oxygen are color-coded.

4. The connecting tips of the external nitrous oxide and oxygen hoses differ so they do not fit if inadvertently reversed, thus preventing incorrect connections.

5. The connecting tips of the portable nitrous oxide and oxygen cylinders are unique so they cannot be reversed accidentally in location on the anesthesia machine.

Where are the potential problems? At least the following exist:

1. The manufacturer may insert the wrong gas in the cylinder in its plant, thus color-coding will not protect from error.

2. The installation of internal gas lines may be incorrect, so that the wrong gas may be delivered unknowingly (as in the Shewan and Lord cases).

3. A human error may occur—administration of pure nitrous oxide without oxygen from the correct sources.

It would appear that some fail-safe systems are needed, in addition to all those factors noted above. The simplest way, it seems, is for the anesthesiologist or anesthetist to smell the gas coming out of the mask before it is administered to the patient. If the present odor is not characteristic enough, perhaps a distinctive additive should be considered to make nitrous oxide easily distinguishable. A signal (visible or audible) should be apparent to the anesthesiologist or anesthetist where 100 percent nitrous oxide is being administered. This is even more important in dental offices or offices of physicians who use general anesthesia for minor office procedures.

Obviously, a fail-safe technique of checking internal gas lines in new hospital construction is an absolute essential. Hospital authorities cannot rely on the contractor's "check list" after new construction to be convinced that pipes are installed and labeled correctly. They should insist upon a gas analysis test to verify the integrity of the system.

In the final analysis, this is not a situation where anesthesiologists, dentists, nurse anesthetists, hospital administrators, and building contractors can play "pass the buck." As Mrs. Shewan, Mrs. Lord, and others have learned, laughing gas is no laughing matter. A.K.



## Emergencies by Appointment

The Maryland Institute for Emergency Medicine, as described in this issue (page 979) by R Adams Cowley, M.D., is a remarkable example of a modern trauma center. It is quite clear that New Jersey needs one or perhaps two such centers now. Costly though they may be, the saving of lives, the application of known concepts, and the development of new ones for the preservation of the trauma victim make such center a bargain.

Cowley's lecture, presented before the Section on Emergency Medicine at our annual meeting last Spring, was even more stimulating than his paper. He used descriptive terms which made the image quite lucid.

—The Golden Hour—"The first 60 minutes following an accident often determine whether a patient will live or die."

—Emergencies by appointment—The Maryland statewide communications center (SYSCOM) coordinates the helicopter transports and "forewarns the trauma center of a patient's arrival, patient's status, and extent of injury," thus the emergency patient arrives "by appointment."

—Preassigned tasks—Each team member knows exactly what to do before the patient arrives.

—Treatment by protocol (algorithm)—Every detail of the treatments to preserve life and limb is spelled out in advance.

—Rehabilitation begins at the time of injury.

The philosophy of the developers of the trauma center is laudatory:

"The trauma center must exist to provide the best treatment science can offer to the worst critically ill and injured patient."

Such an institution, manned by super-specialists in trauma science, is the only hope we have to reduce the appalling statistics which reflect the loss of lives and dollars from highway accidents, air crashes, explosions and fires, industrial accidents, and the like.

—Accidental injury is the leading cause of death among all persons aged one to 38 years.

—60 million persons injured each year.

—115,000 die each year from injuries.

—14 million persons require bed care.

—400,000 persons suffer lasting impairment.

—\$13 billion in lost wages each year.

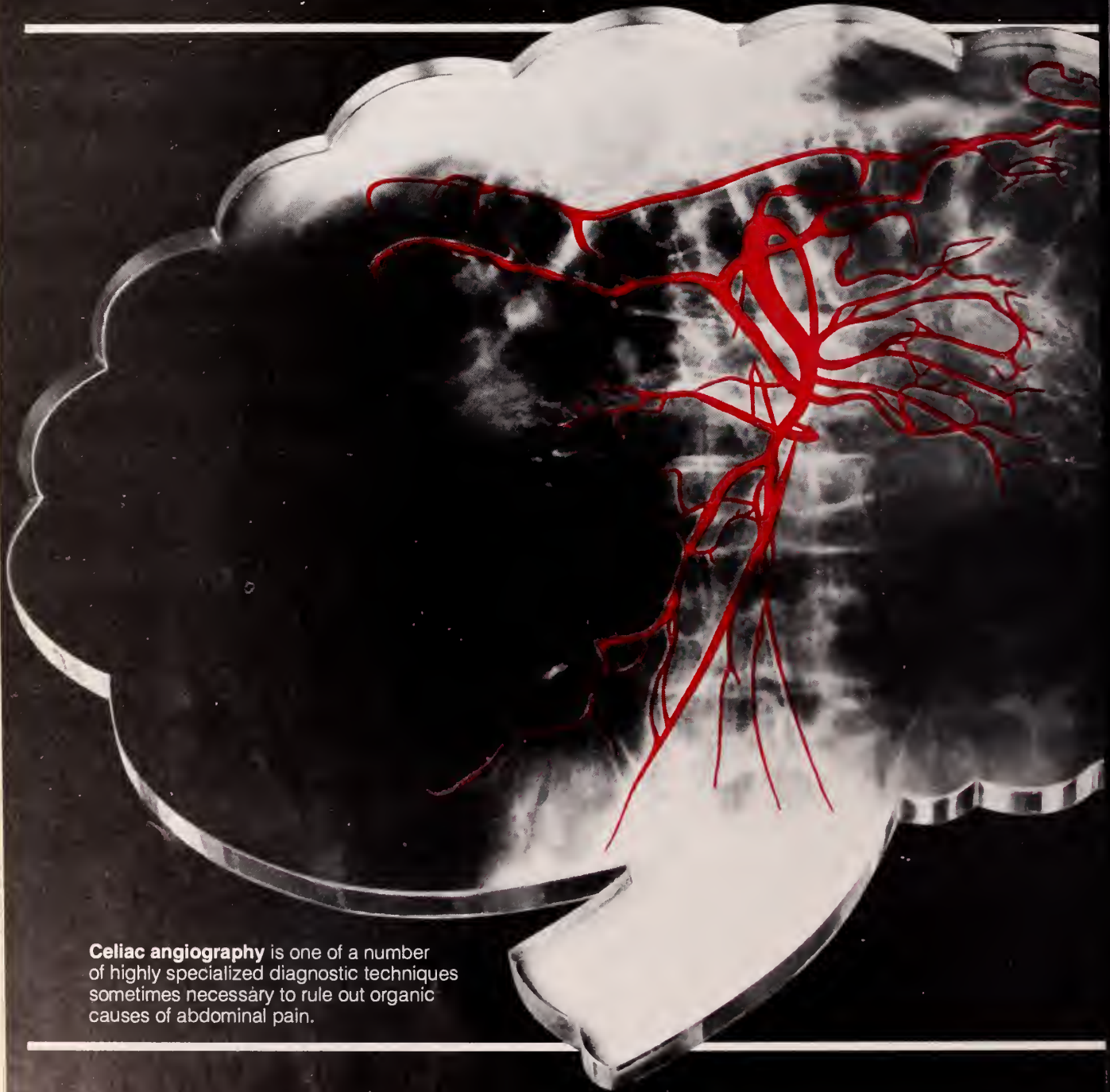
The Medical Society of New Jersey and the leaders in the field of traumatology in this state should use their knowledge and energy to develop one or more New Jersey Institutes for Emergency Medicine as soon as possible. A.K.

### Cover Photos

The photograph of the horse and buggy is used courtesy of the Helene Fuld Medical Center, Trenton. The picture of the Lifemobile was taken by Nicholas J. Palakow who also prepared the CT scans which appeared on the March cover.

# THE LOWER G.I. TRACT: ORGANICALLY SOUND

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\* **Indications:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

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Final classification of the less-than-effective indications requires further investigation.

**Contraindications:** Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide hydrochloride and/or clidinium bromide.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium® (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

**Usage in Pregnancy:** Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

**Precautions:** In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacologic effects of agents, particularly potentiating drugs such as MAO inhibitors and

phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

**Adverse Reactions:** No side effects or manifestations not seen with either compound alone have been reported with Librax. When chlordiazepoxide hydrochloride is used alone, drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are avoidable in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, i.e., dryness of the mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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# ORIGINAL ARTICLES

*Inflammatory and neoplastic bone lesions often vie for the complete attention of the radiologist while there is an attempt to make an accurate x-ray film diagnosis. Tuberculosis of bone and joint is one of those challenging entities whose radiographic appearance seems to present consternation to many observers. The purpose of this paper is to acquaint the younger generation of physicians with the radiographic picture of this old entity as it attacks bones and joints.*

## Osseous Tuberculosis: A Radiographic Challenge\*

**Richard A. Hurwitz, M.D., Jersey City**

In the more endemic areas of the world, many patients with tuberculosis of bone may be encountered. In some of the older, venerated textbooks of radiology descriptions of tuberculous lesions have been well documented,<sup>8</sup> but this is not true in recent publications.

### Case Material

The cases presented in this paper were obtained from the general population in the Republic of South Korea. In all patients, chest films were included as part of the clinical workup. In half the cases with osseous tuberculosis the lungs appeared to be free of both acute and chronic pulmonary parenchymal lesions. The hilar areas were free of nodal changes. The majority of patients x-rayed were in the pediatric and adolescent group. All patients with a suspicious chest x-ray had sputum studies, while those patients who had surgery had tissue sent to the laboratory for culture and histologic study. In some of the cases acid-fast organisms and granulomatous lesions compatible with tuberculosis were not demonstrated, but the histologic picture was reported as representing non-specific inflammation.

The most commonly noted site of involvement was the lumbar vertebral column, followed closely by involvement of the hip joint. Cystic bony tuberculous lesions were demonstrated in the proximal and distal tibia and the humerus. Other sites containing bone and joint changes were the knee, wrist, and ankle regions, cervical and thoracic vertebral column, and pelvic area including the pubic and ischial bones. Tuberculous inflammation of the sacroiliac joints and

a case of tuberculosis of the mandible with sequestra formation also was obtained in this series.

### X-ray Appearance

In most cases, there was a definite lack of any reactive bony process. This included lack of periosteal reaction and lack of bony sclerosis surrounding the inflammatory destructive site. In an occasional case, buttrous formation of the periosteal variety was present in the long bones. In one cystic lesion, a thin indistinct border of sclerosis was present. This occurred in the adult case of tuberculosis of the proximal humerus (Figure 1).

Initial joint manifestations, particularly in the hip, revealed a peculiar propensity to spare the articulating cartilage along the significant



**Figure 1**—Tuberculosis cystica. A fuzzy cortical sclerotic rim surrounds the lytic defect in the medial humeral head. Note the lack of cortical rim directly in contact with the glenoid fossa.

\*From the Department of Radiology, Christ Hospital, Jersey City.





*Figure 2*—Medial hip joint fusion is present. The superior and lateral portions of the hip joint are distinctly intact and preserved.



*Figure 3*—A lytic defect has totally deformed the acetabulum and the femoral head and neck.

weight-bearing surface (Figure 2). However, over a considerable period of time, eventual cartilaginous destruction does take place and fusion of the joint is the inevitable result. Other lesions produced lucent destructive changes in both the femur and acetabulum, resulting in a bizarre pattern (Figure 3). Acetabular protrusion also was seen in chronically diseased hips. With longstanding disease, a prominent loss of bone minerals takes place which results in a washed-out appearance. This is another commonly seen radiographic feature.

After the destruction of the articulating cartilage, ankylosis was noted. This occurred in the wrist, hip, ankle, and particularly in the vertebral column where the disease is commonly manifested. A peculiar resistance to tuberculous infection is seen in the pedicle of the vertebral body. In many instances, preservation of the pedicle in the presence of an extensive lytic process of the body is noted. (Figure 4) If both the pedicle and the body are involved, a neoplastic process becomes a distinct probable cause.



*Figure 4*—The pedicle is intact. An extensive lytic process is present in the vertebral body.



## Discussion

Bovine tuberculosis has been connected with tuberculous involvement in humans in bone and joint structures. However, in the Republic of South Korea, bovine tuberculosis is not a factor as cow milk is not universally consumed. Pulmonary tuberculosis is the prevalent form. Thus, it was most unusual to note that in 50 percent of the cases, the lungs were free of any manifestations of tuberculous disease on chest x-ray examination. There was no direct relationship between normal and abnormal chest x-ray findings and the tuberculous involvement of the patient's bone and joint structures. Skeletal tuberculosis appears to result from secondary hematogenous dissemination from a pulmonary lesion. This pulmonary lesion may be recognized on a conventional chest radiograph as a granulomatous process. Yet the absence of chest x-ray findings may indicate only that these lesions are not recognized roentgenographically or that the host response to the invading organism is such that the common x-ray signs that one is accustomed to see are not produced.

Campos<sup>2</sup> noted that his series of cases of tuberculous bony disease had a high percentage of patients with normal lungs by x-ray. Paradoxically, serious types of bone and joint tuberculosis were observed in practically all patients despite normal lungs. Campos therefore suggested that it was reasonable to admit that in such cases, the infecting bacilli just passed through the lungs almost unchecked because of the particular lack of resistance on the part of the infected host causing an immediate generalized dissemination with skeletal localization.

In this series it was customary for a patient to have a single disseminated site of involvement away from the lungs; there was not one instance of multiple separated sites of skeletal involvement. This observation has not been recognized universally. Cases have been reported in which hematologic dissemination may result also in multiple sites in a single individual patient.<sup>7,9</sup>

## The Radiographic Appearance: The Joint Space — Tuberculosis vs. Bacterial Infection

In 1924, Phemister recorded some of the principal distinguishing characteristics between tuberculous and nontuberculous arthritides.<sup>10</sup> In bacterial infections with proteolytic enzyme involvement, articulating cartilage is destroyed and broken down first at the point of contact and pressure at the site of weight bearing. The reverse is noted in tuberculous arthritis where the tubercular disease seems to spare the articulating cartilage at the weight-bearing point. Therefore, joint cartilage destruction will occur peripherally where tuberculous granulation tissue can grow freely. The central or weight-bearing cartilage areas will show an initial sparing effect.

On radiologic examination, one sees that there is loss of the bony cortical shadow peripherally about the margins of the weight-bearing portions of the articulating surfaces. Reduction occurs in the depth of the joint space at a characteristically late period when comparison is made with the enzymatic destructive change of the bacterially involved joint space. Depending on the time of the initial roentgen examination, it is obvious that the lesion may present itself in varying stages of development.

The change in the knee and wrist areas may be difficult to interpret radiographically following the initial insult. This distinct paucity of radiologic signs at the initial stage of the disease presents a challenge to the radiologist.<sup>3</sup> The later stages of involvement in the knee and wrist may show a lytic destructive process of the articulating area. Eventually, the usual complete erosion of the articulating surface becomes manifest. This may be followed by erosive subchondral bone changes which will then result in the total fusion of the joint (Figure 6).

## Long Bone Changes

In children, there was a propensity for cystic bony involvement in the long bones. These



Figure 5—A clear round "hole" is present in the proximal tibial metaphysis. No sclerosis is noted.

cystic bony lesions, which were metaphyseal in location, were not noted to be circumscribed by any particular bony sclerosis (Figure 5). In one adult, in which a cystic lesion of the humerus was present, a hazy border of sclerosis was noted to surround the lateral aspect of the cystic change. The failure to detect bony sclerosis in the adolescent is contrary to the finding of Karlen, who described well-bordered cystic lesions with a sclerotic zone in the young children among his cases.<sup>5</sup> He felt cystic tuberculosis represents a high resistance already present, where the lesion is walled off early, or resistance rapidly acquired after a period of spread of the disease.

### Vertebral Column Changes

Three main radiologic patterns are encountered in tuberculosis of the vertebral column: *inter-vertebral*, *central*, and *anterior* types.<sup>8</sup> With the first type, the disease is primarily within the disc and results in its destruction early. There is associated body disease, but the predominant change is seen in the disc space (Figure 8) The least common type is the central type in which



Figure 6—Total carpal bone fusion with loss of intercarpal and radiocarpal joint space is present. Soft tissue nodules are noted. Save for normal pip joints and normal first finger joints, a differential diagnosis of rheumatoid arthritis cannot be made with certainty.

the body alone is involved. When involvement produces destruction, the body which shows greatest change anteriorly will collapse anteriorly, producing the gibbus deformity so characteristically seen with tuberculous disease. The anterior type of involvement causes an irregular erosion of the anterior aspect of the vertebral body and it produces a fuzzy margin with a concave defect. (Figure 9) The infection may then spread to other vertebral bodies underneath the anterior longitudinal ligament, which at best seems to provide the pathway of least resistance for the tubercle bacillus. It should be noted that acute staphylococcal infections of the vertebral bodies may produce a purely lytic radiographic picture by itself. It certainly would be necessary to include this particular entity in any differential diagnosis of lytic processes involving the vertebral column.

Sparing of the pedicle or neural arch from tuberculous disease in the face of complete lysis of the vertebral body is a striking finding.



*Figure 7*—The cold abscess is outlined fully with contrast media. The lateral femoral exit point is filled.

This can be considered to be a distinguishing characteristic of tuberculous involvement of the vertebral column; and this sign may be utilized when the differential diagnosis includes neoplastic processes.

It was not uncommon to find draining sinuses far from the sites of initial bony involvement. The cold abscess formation usually described in the old literature and text books manifested itself in several patients<sup>8</sup>. One patient illustrated this problem in which there was bony fusion of the lumbar vertebral column with a draining sinus occurring along the lateral aspect of the proximal femur. Contrast injection demonstrated a sinus tract which extended from the L5 vertebral body to the lateral aspect of the proximal femoral diaphysis. (Figure 7)

## Conclusion

The distinct radiologic change of osseous tuberculosis is a purely lytic destructive process occurring within the bone and joint region. In joint areas where weight bearing is a factor, the cartilage and subchondral bony structures are



*Figure 8*—A combination disc defect and body lytic change is present. The pedicle on the involved side is still intact.



*Figure 9*—A fuzzy concave anterior vertebral body defect is present. Anterior osteophyte bony bridging, which is a reaction to the tuberculous spread beneath the anterior longitudinal ligament, is present between L3 and L4.

initially preserved while the peripheral regions are destroyed. Following bony and joint destruction, it is not unusual for fusion to occur.

A distinct lack of bony sclerosis generally is seen in most cases. When bony sclerosis occurs it is minimal and may reflect some periosteal reaction. One may postulate that where sig-



nificant reactive bony sclerosis exists a secondary inflammatory process of a proteolytic nature may be superimposed on the initial tuberculous lesion. The cystic lesions of tuberculosis noted in both adults and children show little or no reactive sclerosis. A distinctive sparing of the pedicle and neural arch may be considered diagnostic of tuberculosis in the face of severe disc and body lesions. Chest x-rays may be found to be free of tuberculous involvement in 50 percent of the patients in whom positive tuberculous joint and bony defects have been diagnosed.

## References

1. Barton CJ: Tuberculosis of the vault of the skull. *Br Radiol* 34:286-290, May 1961
2. Campos Oswaldo P: Bone and joint tuberculosis and its treatment. *J Bone and Joint Surg* 37A:937-66, Oct. 1955
3. Ganguli Prafulla K: Radiology of tuberculosis of the knee joint. *Rheumatism* 22:90-98, Oct. 1966
4. Hayes John T: Cystic tuberculosis of the proximal tibial metaphysis with associated involvement of the epiphysis and epiphyseal plate. *J Bone and Joint Surg* 43:560-567, 1961
5. Karlen Anders: On cystic tuberculosis of bone. *Acta Scandin Orthoped* 31:163-177, 1960
6. Meschan, Isadore: *Normal Radiographic Anatomy*, Ed 2. Philadelphia, Saunders, 1959.
7. O'Malley Bert W, Zeft Howard J: Disseminated bone tuberculosis. *Am J Med* 38:932-936, June 1965
8. Paul Lester W, Juhl John H: *The Essentials of Roentgen Interpretation*, Ed 2. New York, Hoeber Medical Division, Harper and Row, 1965
9. Seedat YK, Wolpert SM: Disseminated tuberculosis of bone: Report of two cases. *Br Med J* 15:1291-1292, May 1965
10. Winston Joseph M, Hensen James S: Early roentgen diagnosis of tuberculosis of the hip in children. *Radiol* 79:241-249, Aug. 1962

P.O. Box 7100, Jersey City

## Pediatric Brief\*

**Does Diagnosis of Innocent Murmurs Need Reconsideration.** Baum, D. *et al. Abstracts, Ambulatory Pediatric Association*, 1977, p. 39.

Seventy-two children with systolic murmurs of grade 3/6 intensity or less were examined by 1 of 6 "highly regarded" pediatricians who were asked to judge only if the murmur was "innocent" or "organic." Definitive diagnoses were then made by pediatric cardiologists with the aid of laboratory tests. Of 25 children with cardiac disorders, 13 (52%) were diagnosed as having innocent murmurs. Of 47 children without heart disease, 21 (45%) were considered to have organic murmurs. Echocardiography was abnormal in 70 percent of patients with heart disease and chest x-rays were abnormal in 60 percent of children with heart disease. The authors conclude that general pediatricians do not reliably separate innocent from organic murmurs and that chest x-rays and echocardiography would improve diagnostic accuracy.

*Comment:* I find this level of diagnostic mistake a bit hard to believe. I wonder how much more accurate pediatric cardiologists would be! In any case, it is my experience that chest films and other tests (often interpreted in a clinical vacuum by those whose major experience is with adults) frequently add confusion rather than clarification. Trying to minimize any self-interested bias, I believe that direct referral to a pediatric cardiologist, in situations where the interpretation of murmurs is unclear, is most to the patient's benefit.

N. J. Sissman, M.D.

\*Excerpted from CMDNJ Rutgers Medical School *Pediatric Newsletter* (Vol. 1, No. 8, June 1977), Richard H. Rapkin, M.D., Editor. Dr. Rapkin has given *The Journal* permission to reprint this material from time to time.

The responses on the Questionnaire Course entitled "Controversies in the Management of Cancer of the Breast" are reported. Major changes that have taken place in the treatment of breast cancer are emphasized.

# Controversies in the Management of Cancer of the Breast:

A Questionnaire Course\*

**E.J. Lazaro, M.D., B.F. Rush, Jr., M.D.,  
J. Landor, M.D., and E.L. Grimes, M.D.,  
Newark**

The Questionnaire Course has become an established component of the annual scientific meeting of the Section of Surgery of the Medical Society of New Jersey. Details of the objectives, the format, and the implications of this learning experience have been described in detail in previous communications.<sup>1,2,3</sup> Presentation of the responses received from 174 surgeons practicing in New Jersey to a questionnaire on "Controversies in the Management of Cancer of the Breast," and documentation of the approach of most of these surgeons to a variety of clinical situations in patients with breast cancer constitute the basis of this report.

The preferences to the various alternatives indicated in the questionnaire are contained in the following tabulation.

Questions	Preferred Answers of Respondents (%)
1. Your patients have been made aware of a breast lesion more frequently by	
(1) discovering the lesion themselves	81
(2) a physician	17
(3) another individual who is not a physician	0
(4) mammography	1
(5) some other means or you have no opinion	1
2. You have employed needle aspiration of breast masses	
(1) never	5
(2) rarely	29
(3) often	54
(4) always, or almost always	12
(5) no opinion	0

Questions	Preferred Answers of Respondents (%)
3. You employ mammography in breast disease	
(1) routinely	20
(2) never	1
(3) only in symptomatic cases where no mass is palpable or if ill-defined lesions are present, and/or, as a follow-up procedure in observing the contralateral breast for the detection of malignant disease	72
(4) only in the form of contrast mammography to study the ductal system when nipple discharge is present	0
(5) for another reason, or you have no opinion	7
4. The benign breast disease you consider to be most commonly related to the development of breast cancer is	
(1) fibroadenoma	1
(2) mammary dysplasia (cystic hyperplasia)	56
(3) intraductal papilloma	27
(4) fat necrosis	1
(5) another disease or you have no opinion	15
5. In a patient with a bloody nipple discharge and no palpable mass, you usually localize the responsible duct system by	
(1) non-contrast mammography	4
(2) contrast mammography	7
(3) cytology	2
(4) segmental "milking" of the breast	86
(5) another method, or you have no opinion	1
6. On how many occasions have you received a false positive frozen section diagnosis of	

\*Presented in part before the joint meeting of the Sections on Obstetrics-Gynecology, Pathology and Surgery, 211th Annual Meeting of the Medical Society of New Jersey, Atlantic City, New Jersey, May 16, 1977. Dr. Lazaro is Professor of Surgery CMDNJ, New Jersey Medical School; Dr. Rush is Johnson and Johnson Professor and Chairman, Department of Surgery, CMDNJ, New Jersey Medical School; Dr. Landor is Professor of Surgery, CMDNJ, Rutgers Medical School; and Dr. Grimes is Chief of Surgery, Our Lady of Lourdes Hospital, Camden.

<i>Questions</i>	<i>Preferred Answers of Respondents (%)</i>	<i>Questions</i>	<i>Preferred Answers of Respondents (%)</i>
cancer in a benign breast lesion resulting in unnecessary mastectomy?		(3) never employ the "bovie"	12
(1) Never	87	(4) use the "bovie" only for hemostasis but not for raising the flaps	49
(2) Once	11	(5) have another or no opinion	1
(3) Twice	1		
(4) Three or more times	1	12. In your opinion the most appropriate initial treatment for a good risk patient with a one cm carcinoma in the upper inner quadrant of a breast, and no demonstrable spread is	
(5) No opinion	0	(1) extended radical mastectomy	5
7. In a 50-year-old, good-risk female with a two cm mass in the upper outer quadrant of a breast which is reported as malignant on a frozen section you will preferably advise		(2) radical or modified radical mastectomy	61
(1) total mastectomy alone	1	(3) total mastectomy plus radiotherapy	25
(2) total mastectomy with postoperative irradiation	1	(4) total mastectomy alone	4
(3) a modified radical mastectomy	60	(5) other procedure or no opinion	5
(4) conventional radical mastectomy	37		
(5) other advice or no opinion	1	13. Biopsy of the apparently normal contralateral breast in patients with breast cancer should be	
8. Your preferred initial treatment for a post menopausal good-risk patient who has an ulcerating cancer of the breast fixed to the chest wall with small axillary metastases and no demonstrable distant spread is		(1) routinely undertaken	6
(1) radiotherapy	39	(2) considered unnecessary	14
(2) hormonal therapy or chemotherapy	5	(3) carried out only in patients with a strong family history of breast cancer	20
(3) radical mastectomy with or without radiotherapy	24	(4) recommended only for specific histologic type(s) of breast cancer	55
(4) total mastectomy with or without radiotherapy	29	(5) no opinion	5
(5) other therapy or you have no opinion	3		
9. In patients with carcinoma of the breast, simultaneous bilateral mastectomy is indicated		14. Internal mammary node dissection in patients with breast cancer	
(1) never	8	(1) has no place at all in the therapy	48
(2) with biopsy proof of bilateral lesions in an otherwise healthy patient	85	(2) should be routinely employed	1
(3) with histologic proof of a lesion in one breast and mammographic evidence of a lesion in the other breast	6	(3) should be recommended only for those patients with lesions in the inner half of the breast	38
(4) for proven carcinoma in one breast and a strong family history of breast carcinoma	0	(4) should be recommended when the supraclavicular nodes are positive	2
(5) for other option or you have no opinion	1	(5) other option or no opinion	11
10. Your concept of a "modified radical mastectomy" is		15. For complete closure of the "defect" following mastectomy you	
(1) total (simple) mastectomy with axillary node dissection	50	(1) always employ a split thickness skin graft	9
(2) removal of the breast, pectoralis major muscle and axillary nodes	5	(2) frequently employ a split thickness skin graft	10
(3) removal of the breast and both pectoral muscles without axillary dissection	1	(3) sometimes employ a split thickness skin graft	41
(4) total mastectomy with removal of the pectoralis minor muscle and axillary dissection	43	(4) rarely or never employ a split thickness skin graft	40
(5) other procedure or no opinion	1	(5) have no opinion	0
11. When performing mastectomy you		16. A 35-year-old female who had a radical mastectomy two years previously for carcinoma now has proven metastatic disease involving the supraclavicular nodes and multiple osteolytic lesions of the bones. The patient is premenopausal. You would initially recommend	
(1) frequently use the "bovie" for dissection and/or hemostasis	27	(1) adrenalectomy	4
(2) use the "bovie" only occasionally	11	(2) hypophysectomy	1
		(3) oophorectomy	93
		(4) estrogen therapy	0
		(5) other therapy or no opinion	2



<i>Questions</i>	<i>Preferred Answers of Respondents (%)</i>	<i>Questions</i>	<i>Preferred Answers of Respondents (%)</i>
17. A 70-year-old female presents with a four-by-four cm breast mass and numerous small metastatic lesions to skin and bone. Initially, in this case, you would employ		(3) aspirate the mass, and if it is solid proceed directly with biopsy and if malignant proceed with radical (modified) mastectomy	78
(1) radiotherapy	19	(4) as in # (3) but if malignant perform total mastectomy	5
(2) hormonal therapy	31	(5) follow another option or you have no opinion	7
(3) total mastectomy	24		
(4) chemotherapy	23		
(5) other therapy or you have no opinion	3		
18. In your opinion, oophorectomy in patients with breast cancer		23. In a patient suspected of having carcinoma of the breast with ipsilateral, palpable, movable, axillary nodes, the proper first operative step is	
(1) should be employed routinely in premenopausal patients at the time of initial breast surgery	2	(1) biopsy of axillary nodes	15
(2) has no place in breast cancer therapy	0	(2) biopsy of supraclavicular nodes	0
(3) is of value in selected premenopausal or postmenopausal patients	92	(3) biopsy of primary lesion	83
(4) though previously recommended, is now considered of negligible value	5	(4) biopsy of internal mammary nodes	1
(5) other or no opinion	1	(5) other step, or no opinion	1
19. The number of patients you have treated by adrenalectomy for advanced breast cancer in the past 10 years is		24. In your experience, how many cases of occult cancer of the breast have you encountered? (An occult lesion may be defined as one in which there is a small, non-palpable tumor associated with axillary or distant metastases.)	
(1) 0	44	(1) None	20
(2) less than 5	37	(2) Less than 5	66
(3) 5 to 10	8	(3) 5 to 10	9
(4) 10 or more	10	(4) 10 to 20	4
(5) no opinion	1	(5) Over 20	1
20. For a 44-year-old woman who has achieved palliation after oophorectomy and again after adrenalectomy but now has advancing metastatic systemic cancer you would recommend		25. Following mastectomy for carcinoma, reconstruction of the breast with subcutaneous implants has been recommended. You	
(1) hypophysectomy	28	(1) are opposed to this modality of therapy	41
(2) hormonal therapy	10	(2) would like to employ it but have had no opportunity thus far	30
(3) chemotherapy	59	(3) have tried it and subsequently abandoned the procedure	0
(4) irradiation to metastatic sites	1	(4) were initially opposed to the idea, but now are not	19
(5) other or no opinion	2	(5) have no opinion	10
21. A woman develops a painful metastatic lesion of the femur one year after previous radical mastectomy. The preferred initial treatment is		26. A 53-year-old woman has a three-by-four cm firm mass in the upper outer quadrant of the right breast. There are some large firm axillary nodes. She is recovering from an anteroseptal myocardial infarction that occurred six weeks prior. Metastatic surveys are negative. If the lesion is malignant you would recommend	
(1) radiotherapy	83	(1) radical or modified radical mastectomy	31
(2) chemotherapy	10	(2) total mastectomy, followed by x-ray treatment to the axilla, chest wall, supraclavicular and internal mammary chain	10
(3) hormonal therapy	7	(3) irradiation therapy	9
(4) cordotomy	0	(4) irradiation therapy, followed four-to-six weeks later by modified radical or total mastectomy	43
(5) other therapy or no opinion	0	(5) another modality of therapy or you have no opinion	7
22. A 34-year-old woman who is nine weeks pregnant, presents with a firm irregular two-by-four cm nodule in the upper outer quadrant of the left breast. You would preferably			
(1) follow the patient, and biopsy the mass if it is present after delivery	2		
(2) perform mammography, and if negative for malignancy, follow the patient until delivery and then biopsy the lesion	8		

Questions	Preferred Answers of Respondents (%)
27. A 38-year-old woman has a three-by-four cm mass in the upper inner quadrant of the right breast with overlying skin fixation. There are no palpable axillary nodes and no other metastases are present. Biopsy confirms that it is malignant. Your treatment is preferably	
(1) "lumpectomy" and x-ray therapy	2
(2) total mastectomy and x-ray therapy	38
(3) modified radical mastectomy followed by x-ray treatment only if nodes are positive	32
(4) extended radical mastectomy	11
(5) other procedure or no opinion	17
28. Biopsy of a two cm breast nodule in a 34-year-old woman reveals lobular carcinoma <i>in situ</i> . In addition to biopsy of the opposite breast, you would preferably recommend	
(1) radical mastectomy	8
(2) total mastectomy	40
(3) "lumpectomy"	8
(4) modified radical mastectomy	40
(5) other therapy or you have no opinion	4
29. Following mastectomy you discover that the patient has 10 out of 18 involved axillary nodes. You would therefore initially recommend	
(1) irradiation therapy	34
(2) hormonal therapy	1
(3) chemotherapy with a single drug	3
(4) chemotherapy with several drugs	58
(5) other therapy or you have no opinion	4

## Comment

The responses to this questionnaire have brought into focus the following conclusions pertaining to important aspects in the current management of cancer of the breast. (1) Physicians and the utilization of mammography play minor roles in the discovery of breast cancer; the majority of lesions are initially found by the patients themselves. (2) Most surgeons restrict the use of mammography to selected cases of breast disease. (3) Modified radical mastectomy is at present the most commonly employed "curative" procedure for breast cancer. (4) When performing a modified radical mastectomy, 50

percent of surgeons combine total mastectomy with axillary dissection, while 43 percent will, in addition, remove the pectoralis minor muscle. (5) Only two percent of surgeons recommend routine oophorectomy at the time of mastectomy in premenopausal patients, while 92 percent apparently reserve this procedure for those who have already developed distant spread. (6) For the management of metastatic disease following previous mastectomy in the premenopausal patient, 93 percent of respondents agree that oophorectomy is the initial therapy of choice. (7) That adrenalectomy does not occupy a prominent place among the various modalities available for the management of advanced breast cancer is made evident by the fact that 44 percent of surgeons have not utilized this therapeutic approach in the past 10 years, and 37 percent have employed it on less than 5 occasions during this time. (8) Breast reconstruction following removal of the breast for cancer has the approval of 49 percent of the respondents though 41 percent are opposed to this technical consideration. (9) For lobular carcinoma *in situ*, 40 percent prefer total mastectomy and another 40 percent would opt for a modified radical procedure. (10) Following mastectomy in a patient who is found to have significant axillary nodal spread, chemotherapy is preferred over radiotherapy in the initial post-operative treatment.

## References

1. Rush BF and Lazaro EJ: The questionnaire course—An exercise in continuing education. *Bull Am Coll Surg* 58:3, 1973.
2. Lazaro EJ, Rush BF, and Alessi AA: Controversies in the management of arterial insufficiency of the lower extremities—A questionnaire course. *J Med Soc NJ* 73:45, 1976.
3. Lazaro EJ, Rush BF Jr., and Dolan J: Controversies in the management of abdominal sepsis—A questionnaire course. *J Med Soc NJ* 74:234, 1977.
4. Ohio Breast Cancer Survey, 1960-1969. *Am J Surg* 122:765, 1971.

65 Bergen Street, Newark

*Patients who abuse alcohol undergo a characteristic abstinence syndrome upon cessation of drinking, of which seizures ("rum fits") are a feature. Effective drug therapy lessens the risk of abstinence convulsions but extends the period during which the patient is at risk of having such fits. Since long-term anticonvulsant therapy should not be given to such patients, physicians should be aware that these fits may present well beyond the forty-eight hours during which they occur in untreated patients.*

# Alcoholic Epilepsy

## Effects of Treatment on Convulsions following the Cessation of Drinking

**Matthew Menken, M.D., Nancy Buonpane, R.N., and Rhoda Perly, R.N., New Brunswick**

Effective drug therapy can modify considerably the abstinence syndrome that occurs when alcohol ingestion stops after a prolonged period of abuse. In particular, the incidence of convulsions ("rum fits") and delirium tremens is remarkably reduced.<sup>1</sup> Because alcohol abuse also increases the frequency of seizures among patients with convulsive disorders<sup>2</sup>, it is of paramount therapeutic importance to determine whether patients who have convulsions while under treatment for alcohol withdrawal have a persistently lowered seizure threshold. We wish, therefore, to report a prospective series of patients treated for alcohol withdrawal symptoms in a private psychiatric hospital and to record that the temporal profile of abstinence convulsions is modified considerably by vigorous drug treatment.

### Patient Studies

Included in this prospective study were all patients admitted to the hospital with a history of alcohol abuse during the sixteen-month period between October 1974 and January 1976. Because of the history of multiple drug abuse the total number of pure alcohol abuse cases is difficult to delineate precisely but approximates 1135 patients. Sixty-five percent were males and the ages ranged from fifteen to eighty in the entire series.

Thirteen patients of this group had convulsions while in the clinic. One patient was eliminated from the series because he had a long history of

epilepsy, his convulsions were focal, and none occurred during his first month in the hospital. Of the remaining twelve, one had a history of a subdural hematoma and one had had seizures in earlier life unrelated to alcohol ingestion. These two patients were included in the study because they had been under excellent seizure control and the convulsions that occurred in response to alcohol withdrawal were typical of the group as a whole.

Patients were treated with chlordiazepoxide (Librium®) 150 mg. daily for twenty-four hours, 100 mg. daily for the next two days, with subsequent reductions, so that the medication was generally discontinued at the end of ten to fourteen days. The patients also received nocturnal sedation and, in some instances, diphenylhydantoin and/or phenobarbital. No effort was made to standardize or control medications administered, the nature and dosages in each case being determined by clinicians experienced in treating abstinence syndromes. The purpose of treatment in each case was to control abstinence symptoms, including convulsions and delirium tremens.

Three of the patients had seizures within minutes of arrival at the hospital. As outlined in Table 1, the remaining nine patients had seizures occurring between nine and fifteen days after cessation of drinking. In each instance, the convulsions were brief, generalized major motor convulsions; occasionally, several such convulsions occurred within a period of a few hours. Each patient had at least one electro-

\*This study is from The Carrier Clinic Foundation, Belle Mead, New Jersey, and Department of Medicine (Neurology), CMDNJ, Rutgers Medical School, Piscataway.



encephalogram while in the hospital. In each instance, the record was normal or showed non-specific increases in slow and sharp activity. No patient showed specific paroxysmal potentials during the recording. Every patient had a normal neurologic examination. No convulsion occurred longer than forty-eight hours after discontinuing the withdrawal regimen.

Table 1			
Patient	Age	Sex	Interval Between
			Last Drink and First Fit (Days)
1.	37	M	11
2.	50	M	8
3.	58	F	12
4.	24	M	7
5.	15	F	15
6.	43	F	8
7.	49	F	13
8.	62	M	5
9.	31	M	5

### Comment

A relationship between alcohol abuse and convulsive seizures is well established in the literature.<sup>3</sup> In general, patients who abuse alcohol and have fits fall into two groups. The first group consists of those with convulsive disorders who have an increased frequency of seizures after a sustained period of heavy drinking. A second group consists of patients who only have convulsions as part of an abstinence syndrome (so-called "rum fits"). The available evidence suggests that patients in the latter group have a normal seizure threshold except during the period of alcohol withdrawal.

The differentiation of patients in these two groups is of considerable practical importance. Individuals who simultaneously have a convulsive disorder, whether post-traumatic or of other etiology, and a history of alcohol abuse should receive long-term anticonvulsant therapy to protect them from the harmful effects of seizures that occur independent of alcohol ingestion. On the other hand, it appears unnecessary, and perhaps hazardous, to administer long-term anticonvulsant therapy to patients whose only seizures are abstinence convulsions. The experience of most clinicians is that such patients are likely to discontinue their medications precisely when they need

protection the most, and thus may precipitate an attack of status epilepticus, with its attendant risks.<sup>1</sup>

In a classic study of alcoholics, Victor<sup>4</sup> demonstrated that in more than ninety percent of cases abstinence seizures began between seven and forty-eight hours after cessation of drinking, were almost always generalized major motor convulsions without focal signature, and where more than one seizure occurred the period of time between the first and last fit was usually less than six hours. Victor's series consisted of a retrospective analysis of 241 alcoholic patients who presented with convulsive seizures.

When chlordiazepoxide medication is administered to patients within a few hours of the most recent alcoholic intake the effect is twofold. The most significant effect is a marked reduction in the number of patients who have convulsions during the period of abstinence.<sup>1</sup> Thus, during a fifteen-month period, 1135 patients were admitted to the hospital with a history of recent alcohol abuse, yet only twelve patients had convulsions, and three of these were within minutes of arrival, before a therapeutic blood level of medication could be achieved. A precise comparison between the frequency of seizures in treated and untreated patients is not possible because no prospective study has been done (or would be ethically desirable) of untreated alcoholics during abstinence.

A second effect of treatment, however, is that seizures among this group occurred with a very different temporal profile from that described in the literature. Thus, of the twelve patients, only three had fits within the first forty-eight hours after the last drink, in contrast to the cases in Victor's series. Of the remaining nine individuals, however, seizures first occurred between five and fifteen days after entering the hospital.

It appears likely that the administration of medication serves to disseminate the period of abstinence over several days. This effect makes it much less likely for a convulsion to occur

because the noxious substance (or a congener) is eliminated more gradually from the diet. At the same time the patient remains at low risk of a seizure throughout the period of abstinence. Hence, the difference in the temporal profile of convulsions between treated and untreated patients is more apparent than real, in the sense that the first real day of abstinence is deferred for ten to fourteen days by treatment.

## Conclusion

The data, therefore, indicates that when an alcoholic withdrawal medication regimen is prescribed, although the overall incidence of seizures is reduced sharply, the period during which the patient has an increased risk of convulsion is extended to include the entire period of alcohol detoxification, and perhaps a few days thereafter. We suggest, therefore, that among alcoholic patients on a withdrawal drug regimen, a convulsion occurring during the two week period of time following the cessation of drinking should be regarded as a "rum fit"

(abstinence convulsion). It appears that this small sub-group of patients need not be treated with long-term anticonvulsant medication if the convulsions are brief and generalized, if there is no history of convulsions occurring other than during abstinence, if the neurologic examination is normal, and if the electroencephalogram fails to provide evidence of a lowered seizure threshold.

## References

1. Harvey AM, et al: *The Principles and Practice of Medicine*. New York, Appleton Century Crofts, 1972, p 1494.
2. Victor M: Alcoholism. In: *Clinical Neurology*, AB Baker, Editor. New York, Harper and Row, 1975, Volume 11, Chapter 22, p 5.
3. Victor M: The pathophysiology of alcoholic epilepsy. (Research Publication Assoc.) *Res Nerv Ment Dis* 46:431, 1968.
4. Victor, M: A study of epilepsy in the alcoholic patient. *Modern Neurology* (Papers in Tribute to Derek Denny-Brown) 42:555, 1969.

7 Wirt Street, New Brunswick

## Wanted: Referrals of Premature Coronary Artery Disease

The cooperation of physicians is requested in the referral of patients with premature coronary artery disease for studies conducted by the Cardiology Branch of the National Heart, Lung, and Blood Institute at the Clinical Center, National Institutes of Health, Bethesda, Maryland. Patients under 65 years of age with angina pectoris or a history of myocardial infarction are sought for a prospective natural history study to determine whether high-risk and low-risk subgroups can be identified. Of particular interest are patients under 45 years of age who have no known risk factors. Study techniques will include exercise testing with

radionuclide cineangiography, 24-hour ECG tapes, clinical evaluation, and coronary arteriography. Additional screening studies will be carried out for multiple genetic and metabolic risk factors predisposing to early development of atherosclerosis. A complete summary of the work-up findings and recommendations will be sent to the referring physician. Physicians interested in further details or in having their patients considered for admission may write or telephone Dr. Robert M. Stark or Dr. Kenneth M. Kent, Cardiology Branch, National Heart, Lung, and Blood Institute, Building 10, Room 7B-15, Bethesda, Maryland 20014 (301).



# When **impotence** due to androgenic deficiency is driving them apart



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Methyltestosterone U.S.P. – 5, 10, 25 mg.

## New Double-Blind Study ANDROID-25 vs. Placebo\*

\* **WRITE FOR REPRINT:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioğlu, M.D. Hormones for Improved Sexuality in the Male and Female Climacteric. *Drug Therapy*, Sept. 1976.

Is there a true aphrodisiac? How effective are androgens in the management of the male climacteric and male impotence? Article discusses the psychophysiological and hormonal changes in the elderly male and female and therapeutic considerations. The effectiveness of methyltestosterone in the management of male impotence was confirmed by a cross-over, double-blind study using a placebo and Android-25

(methyltestosterone 25 mg.), on 20 males, 50 years of age or older who complained of secondary impotence. Patients received a series of placebo then Android-25, or Android-25 then placebo as follows: 1 tablet/30 days; 2 tablets/30 days; 3 tablets/30 days. Sexual response was evaluated 0 = no change; + = 25% improvement; ++ = 50% improvement; +++ = 75% improvement. Placebo effectiveness was - or ++ in 12.7% of trials. Android-25 elicited a -, ++ or +++ response in 47.2% of trials. There was often a dose related response not observed with the placebo. This effect was not observed in younger patients (age 28-45 years).

**DESCRIPTION:** Methyltestosterone is 17 $\beta$ -Hydroxy-17-Methylandrosta-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1 Eunuchoidism and eunuchism. 2 Male climacteric symptoms when these are secondary to androgen deficiency. 3 Impotence due to androgenic deficiency. 4 Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

**REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg. Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg. Postpuberal cryptorchidism, 30 mg. **REFERENCE:** Robert B. Greenblatt, M.D., and D. H. Perez, M.D.: "The Menopausal Syndrome," *Problems of Libido in the Elderly*, pp 95-101 Medcom Press, N.Y., 1974. **HOW SUPPLIED:** 5, 10, 25 mg in bottles of 60, 250. Rx only.



"Trigger finger" was found in 17.2 percent of 64 diabetics while the control population had a frequency of 2.6 percent. This statistically significant ( $p < .05$ ) increase of "trigger finger" in diabetics has not been documented previously. We believe that "trigger finger" is a manifestation of the "diabetic hand syndrome" and that all patients with this problem should be screened for diabetes.

## Trigger Finger in Diabetes

Leroy Strom, M.D., Cresskill

"Trigger Finger" (trigger thumb, snapping finger, snapping thumb) is a stenosing tenovaginitis, in which there is a constriction of the annular sheath associated with a nodule in the digital flexor tendon. "Triggering" or "snapping" occurs as a result of the catching of this nodule in the constricted tendon sheath during extension, with an abrupt release following the increased force required to pass the obstruction.<sup>1</sup> "Trigger finger" in adults is usually ascribed to trauma or rheumatoid disease<sup>2</sup>, although an association with diabetes mellitus has been suggested.<sup>3,4</sup> When an unusual number of diabetic patients with "trigger finger" was observed and a review of the literature showed that an association between diabetes and "trigger finger" was virtually unrecognized, this study was undertaken.

### Method

The patients were drawn from a suburban private practice consisting of both primary care internal medicine and diabetology. Patients under 30 and those for whom insufficient data were available to determine the adequacy of glucose tolerance (at least two blood glucose

determinations or a glucose tolerance test) were excluded. The diagnosis of diabetes was reserved for those patients with clear clinical evidence of the disease preceding the finding of a "trigger finger." Patients with asymptomatic glucose intolerance were labeled "chemical diabetes." In the final tabulation chemical diabetes was included with clinical diabetes. Standard criteria for interpretation of glucose tolerance were used. Each patient was examined by the author and questioned about present or past symptoms involving the fingers. Only those patients in whom there was a palpable tendon nodule, with demonstrable "snapping" on extension, were labeled as having "trigger finger." In some cases a documented history of previous surgery for "trigger finger" was accepted.

### Results

Of 220 patients studied, 64 were diabetic. Eleven of 15 patients with "trigger finger" were diabetic. (table 1). The increased frequency of "trigger finger" in the entire diabetic group was significant with a  $p$  value of  $< .05$  (chi square test); when insulin-dependent diabetics were compared to other diabetics the results were less significant ( $p < 0.10$ ). The frequency of "trigger

Table 1  
Prevalence of Trigger Finger

	Total	With trigger finger No.	%
Non-diabetic	156	4	2.6
Diabetics	64	11	17.2*
Insulin-dependent diabetics	21	6	28.5**
Chemical diabetics	9	1	11.1
Clinical diabetics not insulin-dependent	34	4	11.8

( \*  $p < 0.05$ )  
(\*\*  $p < 0.1$ )

Table 2 Age of Study Population			
Non-"Trigger Finger" Group	Number	Age range (years)	Average
Non-Diabetic:			
Female	96	30 to 92	55.6
Male	56	30 to 80	52.0
Diabetic:			
Insulin Dep.			
Female	8	33 to 71	50.25
Male	7	31 to 71	53.28
Non-Insulin Dep.			
Female	23	39 to 84	63.0
Male	15	44 to 92	66.3
"Trigger Finger" Group:			
Female	10	35 to 79	62.8
Male	5	38 to 65	54.0

Table 3 Duration of Diabetes (years)			
	Number	Range	Average
Insulin dependent			
a) without TF	15	5-33	16.0
b) with TF	6	3-25	17.6
Non-insulin dependent			
a) without TF	34	1-20	7
b) with TF	4	2-22	10.5
Chemical diabetes			
a) without TF	9	1-10	3.9
b) with TF	1	1	---

(TF = Trigger finger)

finger" did not correlate with age (table 2) or with duration of diabetes (table 3). Of the four non-diabetics with "trigger finger," one had carpal tunnel syndrome, one was a butcher and two were over age 75 with prominent Heberden's nodes (table 4). Of the six insulin-dependent diabetics with "trigger finger," only one was over 70 at the time "trigger finger" became manifest and each had clinical evidence of neuropathy (table 5). The five non-insulin-dependent diabetics with "trigger finger" showed no discernible unifying pattern (table 6), other than the mild symptoms produced by the "trigger fingers." None of this group required treatment. Ten of the 15 patients with "trigger finger" were female (table 2). This apparent female preponderance appears less significant when compared with the sex ratio of the entire group (62 percent female) or of the diabetic group (59 percent female).

## Discussion

The high prevalence of "trigger finger" in this

study group is probably not a true representation of this phenomenon, since the study was initiated by the chance observation of an unusual number of diabetics with "trigger fingers" observed in a short period of time. The increased frequency of "trigger finger" in diabetic patients as compared to non-diabetics, although statistically significant, does not necessarily suggest an etiologic relationship between diabetes and "trigger finger." However, when it is noted that each of the non-diabetic patients with "trigger finger" had either carpal tunnel syndrome, Heberden's nodes, or a history of repeated trauma, while most of the diabetic patients had none of these predisposing factors, a causal as well as statistical relationship between diabetes and "trigger finger" becomes an attractive hypothesis.

In a study comparing the effects of surgical and injection treatment of "trigger fingers," Kolind-Sorensen<sup>1</sup> used the term "primary

trigger finger" for cases occurring in otherwise normal persons, and "secondary trigger finger" for cases occurring in patients with rheumatoid arthritis, diabetes mellitus, or osteoarthritis with prominent Heberden nodes. No information was given on the number of diabetics in this group, or the relative prevalence of "trigger finger" in diabetics.

Hueston, *et al.*<sup>2</sup> postulates that the initial change which eventuates in the phenomenon of "triggering" is thickening and narrowing of the tendon sheath. The constricting ring thus formed near the metacarpophalangeal joint

causes "bunching up" of the tendon as it slides through and eventually leads to the formation of a nodule on the tendon. The nodule then may be caught by the constriction and, on forceful release, a "snap" occurs. He refers to carpal tunnel syndrome and Dupuytren's contracture as associated stenosing conditions. The increased frequency of Dupuytren's contracture in diabetics was reconfirmed by Spring, *et al.*<sup>6</sup> who noted that median and ulnar nerve conduction velocities were abnormal in both diabetic and non-diabetic subjects with Dupuytren's contracture. This led to the conclusion that the neuropathy of diabetes is responsible

Table 4  
Trigger Finger in Non-Diabetics

Sex	Age	Finger Involved	Treatment	Comments
M	50	right thumb	local injection with relief of symptoms	(1) treated acromegaly (2) occupation butcher (3) treated 2 months before study
F	78	left 3rd	local injection with relief symptoms	Heberden's nodes
F	50	bilateral thumb	no therapy	carpal tunnel syndrome
F	79	right 3rd	no therapy	Heberden's nodes

Table 5  
Trigger Finger in Diabetes  
Insulin Dependent

Sex	Age	Duration of Diabetes	Description of Diabetes	Occupation	Finger Involved	Therapy	Comments
F	75	8 years	Insulin dependent since onset, associated with myocardial infarction, not obese Heberden's nodes interosseous muscle atrophy	housewife	right thumb	local injection with relief of symptoms	treated 3 months before study
F	35	25 years	juvenile onset retinopathy atrophy of first interosseous space	housewife	both 3rd fingers	none	
F	42	23 years	juvenile onset, retinopathy and neuropathy	housewife	right 3rd finger	none	
M	38	23 years	juvenile onset, atrophy of first interosseous space	business executive	right 2, 3 and 4th left 3, 4	surgical treatment in past, no therapy currently symptomatic	
F	79	24 years	obese, ketosis resistant, insulin therapy past 10 years because of symptomatic hyperglycemia	none	right 3rd	surgical treatment 10 years ago	
F	55	3 years	presentation in ketoacidosis; disabling neuropathy and amyotrophy	housewife	bilateral thumbs	none	



Table 6  
Trigger Finger in Diabetes  
Non-Insulin Dependent

Sex	Age	Duration of Diabetes	Description of Diabetes	Occupation	Finger Involved	Therapy	Comments
M	57	2 years	obese, type IV hyperlipidemia, diet controlled after brief course of sulfonylurea therapy	retired office worker	right 3rd	none	hypertension glaucoma, COPD, on multiple medications
F	70	10 years	obese, aglycosuric, sulfonylurea treatment	retired school teacher	right 3rd	none	hypertension
M	65	1 year	chemical diabetes, abnormal GTT 1 year ago, normal FBS on diet therapy	retired officer	both 5th fingers	none	none
F	65	22 years	asymptomatic hyperglycemia diet therapy	housewife	right thumb	none	none
M	60	3 years	obese; poorly controlled on sulfonylureas	businessman	right thumb	none	none

for the high incidence of Dupuytren's contracture in diabetics. Neuropathy is not a requirement for hand abnormalities in diabetes. Examining children with diabetes, Grgic, *et al.*<sup>7</sup> found a strikingly high frequency of finger joint stiffness and contractures. The fifth fingers were most frequently involved with symmetrical spread to other fingers occurring over a two-year period. There was a positive correlation between severity of joint stiffness and duration of diabetes. No clinical evidence of neuropathy was noted in these children, and it was suggested that finger stiffness and contractures might be a manifestation of accelerated aging resulting in decreased elasticity and toughening of connective tissue.

Jung, *et al.*<sup>5</sup> used the term "diabetic hand syndrome" to describe the hands of adult diabetics with atrophy of intrinsic hand muscles (interossei, thenar, and hypothenar), atrophy of palmar tissue, and neuropathy of the median and ulnar nerves documented by slowed nerve conduction velocity across the wrist. Flexion contractures of the interphalangeal and metacarpal-phalangeal joints were frequently present with multiple joints usually being involved in a symmetrical manner. The severity of this joint involvement correlated with the severity of neuropathy and with the duration of diabetes, but not with the presence of Dupuytren's contracture or carpal tunnel syndrome.

Thus it is apparent that a variety of manifestations of connective tissue thickening may be associated with the diabetic hand, and diabetic neuropathy may be an underlying cause. Although some of the patients in this study had clinical evidence of neuropathy, a conclusion cannot yet be drawn on the relationship between "trigger finger" and neuropathy. A study correlating electromyographic measurements with "trigger finger" is in progress. It may be inferred, however, that "trigger finger," like Dupuytren's contracture and finger joint stiffness, is an additional expression of the "diabetic hand syndrome."

## References

1. Fahey John J, Bollinger John A: Trigger finger in adults and children *J Bone & Joint Surg* 36-A:1200-1218, 1954
2. Hueston JT, Wilson WF, Soin K: Trigger thumb. *Med J Australia* 2:1044-1045, 1973
3. Kolind-Sorensen V: Treatment of trigger fingers. *Acta Orthop Scandinav* 41:428-432, 1970
4. Boyes JH: *Bunnell's Surgery of the Hand*, 5th ed. Philadelphia, Lippincott, 1970, p. 446
5. Jung Y, Hohmann TC, Gerneth JA, Novak J, Wasserman RC, D'Andrea BJ, Newton RH, Danowski TS: Diabetic hand syndrome. *Metabolism* 20:1008-1015, 1971
6. Spring M, Fleck F., Cohen BD: Dupuytren's contracture: Warning of diabetes. *NY State J Med* 70:1037-1041, 1970
7. Grgic A, Rosenbloom AL, Weber FT, Giodano B, Malone JI, Shuster JJ: Joint contracture—common manifestation of childhood diabetes mellitus. *J Pediatr* 88:584-588, 1976

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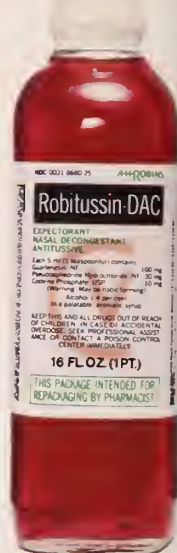
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*Annual figures on lead levels among five-year-old school children suggest that progress has been made in Newark's battle against pediatric lead poisoning. Over the three years sampled, there was a consistent increase in the proportion of children with lead levels below 30ug/dl for all ethnic groups. Furthermore, the figures for the school years 1974-1975 and 1975-1976 (which are more comparable because of changes in testing methods after the first year) show that the percentage of children with lead levels less than 30ug/dl rose from 49 percent to 71 percent among blacks, the largest ethnic group examined.*

## Reduction in Lead Levels Among Children in Newark\*

**D. Gause, D.P.H., W. Chase, M.D.,  
J. Foster, B.S., and D. B. Louria, M.D.,  
Newark**

In 1972, an article in this journal indicated that Newark's pediatric lead poisoning problem was more serious than anywhere else in the United States.<sup>1</sup> It was estimated that 34 percent of Newark's children had lead levels of 50ug/dl and above, exceeding figures cited from studies in Baltimore, Cleveland, Chicago, and New York.<sup>2</sup>

Most lead poisoning is due to eating paint chips, which often easily are accessible in the old deteriorated housing especially prevalent in poor, non-white ghetto areas. Since World War II, legislation has restricted the amounts of lead in interior paints. However, a 1970 Newark block study of 77 apartments housing children in a deprived area found that 94 percent of the households had lead levels exceeding the legal one percent.<sup>4</sup>

The problem of lead poisoning in Newark has been recognized well by public health officials; for almost six years organized lead screening among children has been conducted as a collaborative venture of the Newark Department of Health and the Department of Preventive Medicine and Community Health of the New Jersey Medical School. Efforts at control and prevention have been combined with screening. Treatment centers have been established and multimedia educational programs have been aimed at parents and physicians. Since community awareness of the lead poisoning problem is useless without a system to control the sources

of exposure, the Newark Health Department inspects the housing of children found to have elevated blood levels (50ug/dl or above), and notifies the owners of such buildings of code violations when lead contamination exceeds the legal limit.

This report aims to demonstrate progress in the attack on Newark's lead poisoning problem. The only other attempts to evaluate efforts at controlling lead poisoning in Newark have been limited to studies of trends in hospital admissions of children with lead poisoning.<sup>3</sup> An alternative approach taken here is to measure trends in lead levels among a defined stable homogeneous group over time. Such a group has been provided by the Newark Board of Education, which has been testing school children (mostly five and six year olds) for lead levels since 1973. Trends for this group are much more likely to reflect representative *changes* in lead levels for Newark than are figures on screening tests for the entire city, since city-wide screening efforts varied geographically from year to year in a manner likely to reflect different pockets of lead concentration. Although the data do not include information on children aged one to three, among whom lead poisoning is most prevalent, there is little reason to suspect that the trends for five and six-year olds are much different.

### Methods

Lead screening was performed under the super-

\*This study is from the College of Medicine and Dentistry of New Jersey, Department of Preventive Medicine and Community Health, New Jersey Medical School and the Board of Education of the City of Newark, New Jersey.



vision of the Newark Board of Education. Permission for testing was requested from parents of prekindergarten and kindergarten students during the school years 1973-74, 1974-75, and 1975-76. During the three academic years, 34, 33, and 37 percent respectively of the prekindergarten and first grade students were studied. All Newark schools were involved, and sampling patterns were relatively similar during each of the three years.

After cleansing and lancing the middle finger on each child, trained school nurses collected drops of blood on filter paper for micro-method analysis. All samples were analyzed for lead levels by the Environmental Toxicology Division, Department of Preventive Medicine and Community Health, New Jersey Medical School, using atomic absorption spectrophotometry.

When collecting blood samples on filter paper by the micro method, a certain degree of contamination is unavoidable. Contaminated samples usually yield lead levels above 50ug/dl; thus, to distinguish between false positives and true positives, an additional erythrocyte protoporphyrin (EP) test was done on all results above 50ug/dl. This EP test, however, was not performed prior to 1974, so that tests above 50ug/dl for 1973-74 contain proportionately more false positives than in the following two years.

## Results

Figure 1 and Table 1 show a definite lowering trend in lead levels in recent years among black,

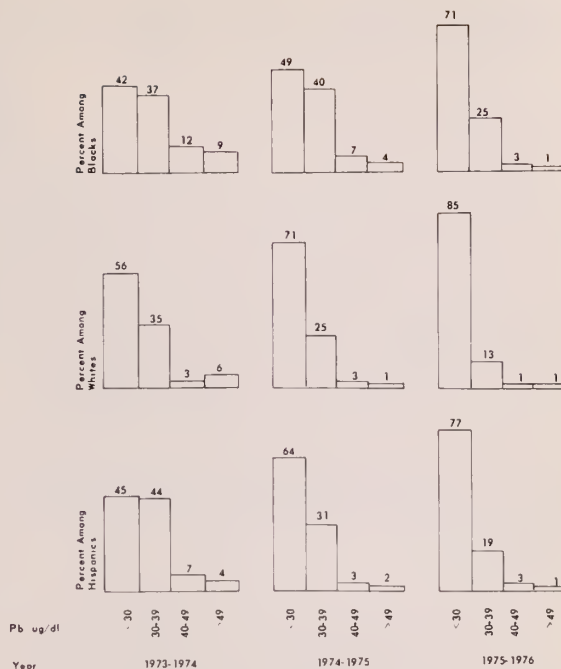


Figure 1—Relative frequency of lead levels among five-year-old children tested by the Newark Board of Education by year

white, and Hispanic children. Data on six-year olds, which are not shown because of smaller sample sizes, demonstrate the same pattern as that seen among five year olds.

Because of the likelihood of more false positives above 49ug/dl in 1973-74, the changes between the second and third years are more valid. However, since less than 10 percent of the tests in 1973-74 were above 49ug/dl, adjusting for the inflation among this group would alter only

Table 1  
Relative Frequency of Lead Levels Among 5 Year Old  
Children Tested for the First Time by the Newark  
Board of Education

Year	Ethnicity	Number	Percent of Tests			
			<30	30-39	40-49	>49
73-74	Black	806	42	37	12	9
74-75	Black	769	49	40	7	4
75-76	Black	874	71	25	3	1
73-74	White	134	56	35	3	6
74-75	White	185	71	25	3	1
75-76	White	192	85	13	1	1
73-74	Hispanic	138	45	44	7	4
74-75	Hispanic	171	64	31	3	2
75-76	Hispanic	273	77	19	3	1



slightly the lowering trend in the lead levels over the three-year period.

## Discussion

Although the three-year test results on five-year-old school children represent only a small fraction of the at-risk children in Newark, the substantial increase in the proportion of the five year olds with blood concentrations below 30ug/dl suggests that considerable progress has been made in Newark's battle against pediatric lead poisoning. (City-wide lead-screening figures, comprising mainly pre-school children, also indicate a decline in lead levels in recent years but, as explained earlier, these data may be less representative than the data for school children).

However, despite this overall lowering of lead levels, 494 asymptomatic school children (10 percent of the 4,939 tested) were identified with lead levels above 39ug/dl. Of these, 85 percent were black, 6 percent white and 9 percent Hispanic. Those children obviously merit careful assessment, and this is being done presently.

This raises a critical question. Can increased lead burdens in asymptomatic children be related to educational underachievement or deviant social behavior in school? There are some data suggesting that lead intoxication in the absence of clinical encephalopathy can lead to intellectual impairment.<sup>5 6 7</sup> Other studies have related asymptomatic lead poisoning to impaired fine coordination, and, in one study, to

aberrant behavior.<sup>7 8</sup> As a means of exploring this question we shall undertake a follow-up study matching those with blood concentrations over 30ug/dl to those with levels under 20ug/dl. There are obvious difficulties in attempting to have the cases and controls truly comparable, but it seems imperative to determine whether some of the educational and behavioral problems indigenous to many inner-city populations may be due, in part, to the brain-damaging effects of subtle lead intoxication.

## References

1. Browder AA: Lead poisoning in Newark. *J Med Soc NJ* 69:101, 1972.
2. Browder AA, Joselow MM, and Louria DB: The problem of lead poisoning. *Medicine* 52:121 (1973).
3. Browder AA, Joselow MM, Louria DB, Lavenhar M, and Foster J: Evaluation of screening programs for childhood lead poisoning by analysis of hospital admissions. *Amer J Pub Health* 64:914 (1974).
4. Browder AA, Joselow MM, and Louria DB: Unpublished Data.
5. Byers R and Lord EE: Late effects of lead poisoning on mental development. *Amer J Dis Child* 66:471 (1943).
6. Cohen GJ and Ahrens WE: Chronic lead poisoning. *J Ped* 54:271 (1959).
7. de la Burd  B and Choate M: Does asymptomatic lead exposure in children have latent sequelae? *J Pediatr* 18:1088 (1972).
8. Lansdown RG, Clayton BE, Graham PJ, Shepherd J, Delves HT, and Turner WC: Blood lead levels, behavior and intelligence: A population study. *Lancet* 1:538 (1974).

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# CASE REPORTS

*A further case of complete urethral duplication is presented. Salient features of the anatomy, symptomatology, diagnosis, and therapeutic management of the anomaly are considered. The ease with which this lesion can be overlooked is emphasized.*

## Duplication of the Urethra\*

**Bernard D. Pinck, M.D. and  
Perry Cohn, M.D., Passaic**

Duplication of the urethra within a single penile shaft is a rare anomaly. To date, less than 40 cases have been recorded in the literature in which two urethrae emerge separately from the bladder and extend independently through the penis to terminate on the glans with two discrete apertures. Forgaard and Ansell<sup>1</sup> have described an instance of trifurcation of the anterior urethra, the only publication of such an anomaly.

### Anatomic Features

Accessory urethral canals are generally situated dorsal to the true urethra although the ventral position has been recorded. The duplication may be complete or incomplete, and it is well known that short accessory channels are occasionally seen in association with hypospadias. The false urethral ducts may be rudimentary or well developed, but the true urethra is essentially normal. Complete double urethra is collateral of reduplicated penis, and may occur with partial diphallus and/or a double bladder. The accessory urethra can also be present as an epispadias with dorsal bladder opening and dorsal gutter. Ravitch<sup>2</sup> has reported duplication of the urethra in conjunction with congenital doubling of the colon:

As the length of the accessory canal may vary, so also does the site of the external aperture, inconstantly appearing on the coronal sulcus, the penile shaft, the penoscrotal junction, as well as on the glans.

Urethral reduplication, therefore, may be divided into four categories:

1. A blind accessory urethra with meatus opening externally on the skin or internally into the urethra. The latter easily

can be confused with urethral diverticulum.

2. A "Y" shaped deformity in which one end communicates with the surface of the penis and the other joins the urethra at varying points proximal to the external meatus.

3. Complete duplication of the urethra wherein the accessory channel lies parallel to the normal urethra and both channels communicate at one end with the glans and at the other end with the urinary bladder.

4. An accessory canal which conveys seminal fluid and is independent of the urethra. This may represent an ectopic ejaculatory duct emptying at various sites along the shaft of the penis.

Although a consensus has not been reached on the embryologic basis for these anomalies, the most acceptable explanation is that the condition results from a continuation of the splitting process of the urorectal septum with a consequent bifurcation of the urethral anlage into a dorsal and ventral portion, partially or complete. Other etiologic explanations are bifurcation of the urethral gutter, or fusion, too far posteriorly and too late in time, of the paired buds forming the genital tubercle.

### Symptomatology

Double urethra is generally an asymptomatic anomaly and certain cases must pass unnoticed because there is no apparent visible abnormality, or because no particular symptom has arisen requiring treatment. The common clinical disturbances which draw attention to the condition are abnormal penile appearance, double urinary stream, infection, or incontinence. Where incontinence is the presenting feature, it is usually minimal in degree and occurs briefly on stress. Incontinence is referable to extension of the accessory canal into the bladder in the absence of a capable sphincter. Infection is the more common symptom in incomplete reduplication and appears as persist-

\*From the Department of Pediatrics and Urology, Beth Israel Hospital, New Jersey

ing discharge, often resistant to therapy and necessitating surgical excision. Occasionally there may be obstruction at the communication of the accessory canal with the urethra, provocative of cyst or abscess formation. Unless a concurrent penile defect contravenes, sexual function is undisturbed by urethral duplication.

### Diagnosis

The external observation of two urethral openings at once points to the diagnosis, and the expulsion of urine through both apertures in a double stream confirms the initial impression. The investigative modalities of urologic search will provide corroborative evidence. A voiding cystourethrogram or a retrograde urethrogram with injection of contrast material into both channels may be sufficient. Urethroscopy does not ordinarily visualize the communication between the two tracts because the accessory opening is immediately above the bladder neck and defies detection. However, if a catheter or filiform stent has been passed through the supplementary canal, this may be observed cystoscopically entering the bladder through a separate opening.

### Management

Therapy often is dependent on the degree of symptomatic discomfort. In the absence of infection, discharge, double stream, or incontinence, the condition may be ignored as an interesting but innocuous anomaly. Surgical excision is called upon when clinical disturbance is significant or in association with correction of other penile defect. Slotkin and Mercer<sup>3</sup> and Casselman and Williams<sup>4</sup> report total extirpation of the accessory urethra where epispadias and hypospadias with chordee were attendant defects. Campbell<sup>5</sup> has recommended obliteration of the secondary channel with the injection of sclerosing substances. To accomplish the same purpose, fulguration and curettage of the epithelium lining have been performed with questionable effectiveness. Gross and Moore<sup>6</sup> favor removal of the disturbing supplementary tunnel when symptomatic and have expressed dissatisfaction with attempts to create a union between the urethra by disruption or ablation of the intervening

septum. Atherton, Atherton, and Sexton<sup>7</sup> relate a successful case where the septum was severed by electrocautery.

### Case Report

A one-year-old boy was first seen in February, 1966 because of presumed hypospadias detected at three months. The appearance of double urinary stream not previously observed prompted urologic consultation. The child's birth history and early development were uneventful and no evidence of other congenital irregularity was disclosed. Examination revealed two urethral openings; a large aperture situated just above the frenum and a smaller, somewhat constricted meatus on the dorsum of the glans slightly proximal to the tip. A broad flow of urine emerged from the lower opening and a forceful, but narrower stream from the dorsal orifice. Probing disclosed patency of both channels. The penis in all other respects appeared normal.

Excretory urography demonstrated normal kidneys and ureters with satisfactory function. Two small catheters introduced into both channels passed easily into the bladder (Figure 1). The upper, narrower urethra would not admit a #12F panendoscope, but the lower tube permitted easy passage of this instrument into the bladder. Cystoscopic examination revealed that the stent in the dorsal urethra emerged in the bladder from a slit-like orifice on the anterior wall of the vesical neck. Cystography demonstrated the bladder to be of normal appearance and contour with no evidence of ureteral reflux. The child had no dysuria and urine cultures were sterile. Consequently it was deemed that corrective measures were not feasible or expedient at this time.

The patient was reexamined at age two and it was noted that the supplementary channel no longer expelled urine although it was totally patent. Physical and mental develop-



Figure 1—Catheters entering bladder through two urethrae

ment had been normally progressive. There were neither subjective nor clinical complaints of urinary dysfunction.

In March, 1970 urological reevaluation was again performed. The tiny accessory meatus situated just behind the tip of the glans at its dorsal aspect permitted introduction and passage of a #4F ureteral catheter. The normal urethral aperture was in a position of balanitic hypospadias. A voiding cystourethrogram revealed the discharge of dye through only the lower urethra in a single forceful stream. Urine cultures failed to produce bacterial growth.

The patient has been followed at intervals since. There has been no evidence of urinary disturbance or infection, and in the absence of disability associated with the anomaly, surgical intervention has not been regarded as indicated.

## References

1. Forgaard DM, Ansell JS: Trifurcation of the anterior

urethra: A case report. *J Urol* 95:785-787, 1966

2. Ravitch MD: Hind gut duplication-doubling of colon and genital tracts. *Ann Surg* 137:588-601, 1953

3. Slotkin EA, Mercer A: A case of epispadias with a double urethra. *J Urol* 70:743-746, 1953

4. Casselman J, Williams DI: Duplication of the urethra. *Acta Urologica Belgica* 34:535-538, 1966

5. Campbell MF, Harrison JH: *Urology*, Vol 2. Philadelphia, Saunders, 1970, pp. 1591-1594

6. Gross RE, Moore TC: Duplication of the urethra: Report of two cases and summary of the literature. *Arch Surg* 60:749-761, 1950

7. Atherton L, Atherton LD, Sexton M: A method of correcting double urethra in a man. *J Urol* 98:99-101, 1967

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## Blacks and Orientals Seek Surgical Nose Changes

The "nose job"—plastic surgery in which a nose is reduced and reshaped—is becoming more popular among Americans of black or Oriental heritage, says a report in the August issue of the AMA's *Archives of Otolaryngology*.

"In this era of ethnic and racial pride, it is somewhat surprising that a large percentage of non-Caucasians undergo rhinoplastic surgery," says Sheldon S. Kabaker, M.D., of the University of California Medical School at San Francisco. Sometimes the objective is to gain a more normal ethnic appearance, but the majority of the patients seek a more Caucasian appearance, Dr. Kabaker says.

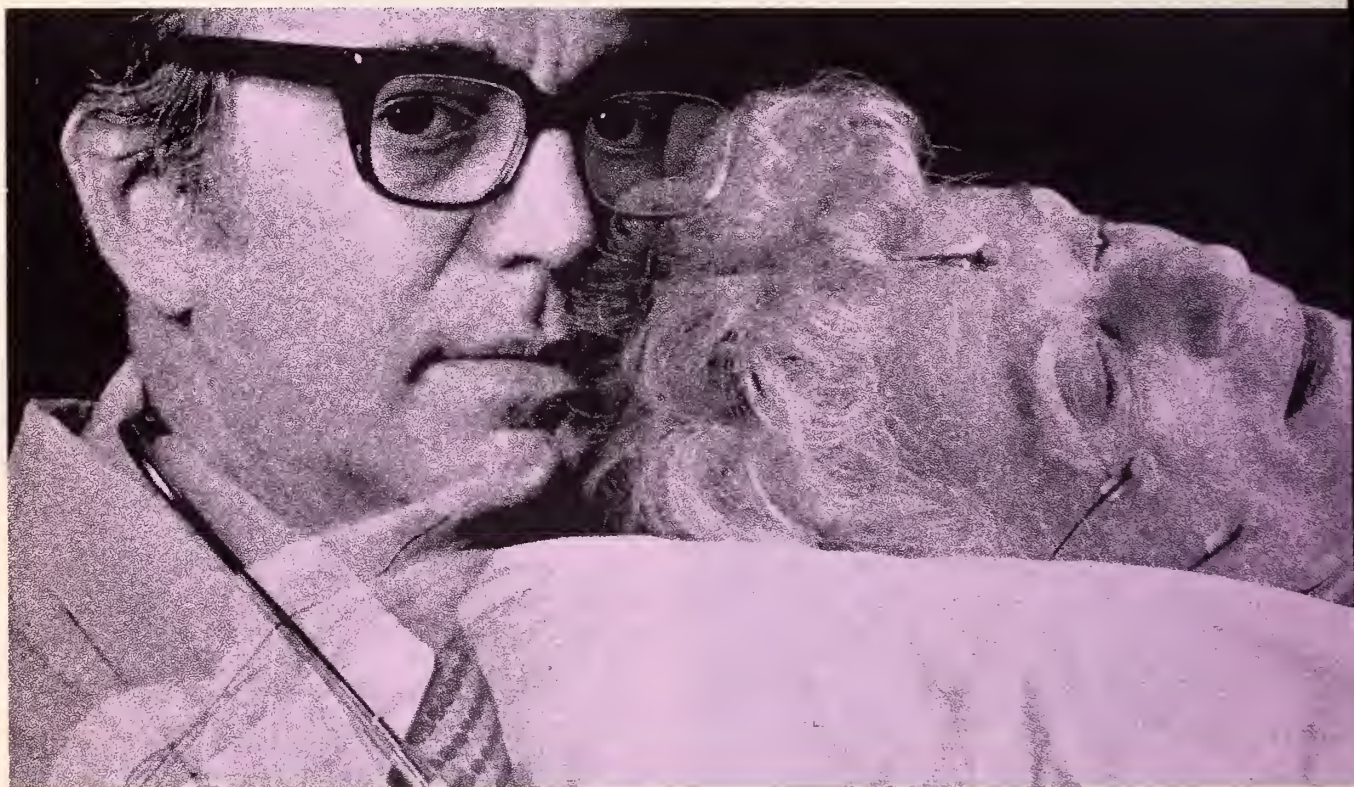
"The performing arts and the advertising media still emphasize Caucasian standards of beauty, even when catering to black and Oriental consumers. The Caucasian prototype

of beauty goes beyond the United States. Glamor magazines in the Orient feature Caucasian models in some of their advertisements." These influences lead these people to seek nose surgery, he says.

Achieving a thin, finely sculptured nasal appearance in a non-Caucasian usually is not possible, and even if it were, it would not be in harmony with the rest of the facial features. Persons with a wide and flat nose "will be content with a less than perfect result and these persons accept the visible scarring that may occur with rhinoplastic surgery." Dr. Kabaker explains the intricate surgery used on the nose, and reports on a number of specific cases. "It must be emphasized that the goal of this type of rhinoplasty is to improve the harmony of the facial features and can never produce an ideal Caucasian nose," he concludes.



# If you've been prescribing chloral hydrate or glutethimide for insomnia, there's good reason to reconsider.



Before prescribing Dalmane (flurazepam HCl), please consult complete product information, a summary of which follows:

**Indications:** Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

**Contraindications:** Known hypersensitivity to flurazepam HCl.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

**Usage in Pregnancy:** Several studies of minor tranquilizers (chlordiazepoxide, diazepam, and meprobamate) suggest increased risk of congenital malformations during the first trimester of pregnancy. Dalmane, a benzodiazepine, has not been studied adequately to determine whether it may be associated with such an increased risk. Because use of these drugs is rarely a matter of urgency, their

use during this period should almost always be avoided. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

**Precautions:** In elderly and debilitated, limit initial dosage to 15 mg to preclude oversedation, dizziness and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

**Adverse Reactions:** Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea,

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In parallel sleep laboratory studies among insomniacs, chloral hydrate 1 Gm lost most of its effectiveness within two weeks, while Dalmane (flurazepam HCl) 30 mg remained effective in both inducing and maintaining sleep throughout the treatment period.

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Glutethimide 500 mg lost all effect on sleep induction and maintenance by the end of the two-week administration period. Dalmane 30 mg, however, was still effective—without repeating dosage during the night.

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(flurazepam HCl) <sup>Ⓢ</sup>IV

30-mg and 15-mg capsules

## Unsurpassed record of efficacy and safety

constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase.

**Dosage:** Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

**Supplied:** Capsules containing 15 mg or 30 mg flurazepam HCl.

### References:

1. Kales A, *et al*: *Arch Gen Psychiatry* 23:226-232, Sep 1970
2. Kales A, Kales JD, Martin ED; *Drug Ther* 5:31-39, Jun 1975
3. Kales A, Kales J: Recent advances in the diagnosis and treatment of sleep disorders, in *Sleep Research and Clinical Practice*, edited by Usdin G. New York, Brunner/Mazel Inc., 1973, p. 61

4. Robinson DS, Amidon EL: Interaction of benzodiazepines with warfarin in man, in *The Benzodiazepines*, edited by Garattini S, Mussini E, Randall LO. New York, Raven Press, 1973, p. 641

5. Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ

6. Young DS, Pestaner LC, Gibberman V: *Clin Chem* 21:110-432D, Apr 1975

7. Moore JD, Weissman L: *J Clin Pharmacol* 16:241-244, May-Jun 1976

8. Spiegel HE: Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ

9. Kaplan SA, *et al*: *J Pharm Sci* 62:1932-1935, 1973



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*A case of bilateral conjunctival lymphoma in a 37-year-old man is reported. His presenting symptom in early 1972 was the swelling of both lower eyelids with minimal conjunctivitis. He was otherwise in good health and showed no signs of systemic disease at his initial ophthalmological examination. An orange-colored, firm, smooth mass was observed in each lower fornix. After surgical removal and histological evaluation, these masses proved to be poorly differentiated lymphocytic lymphoma and the patient was referred to an oncology service. A full-blown picture of systemic lymphomatous disease evolved rapidly in the next few months and a vigorous chemotherapeutic regimen was started. At present the patient is in a stable condition and is functioning normally.*

## Malignant Lymphoma Presenting as Bilateral Swelling of the Eyelid

**N. H. Smith, M.D., Ph.D.,  
W. T. Rados, M.D., F. B. Cohen, M.D.,  
and A. A. Cinotti, M.D., Newark**

Lymphoma rarely affects the eye as the initial manifestation of systemic disease.<sup>1</sup> Of all patients with lymphoma, one to six percent have involvement of the globe, orbit, lacrimal gland, eyelid, or brow at some stage in the disease.<sup>1,2</sup> Of these, however, only one to two percent present at these sites initially; the remainder spread by direct extension from adjacent tissues or by dissemination by blood or lymph.<sup>1,2</sup> The number of cases of eyelid and conjunctival lymphomas is very small, indeed.<sup>3</sup>

Among the few specific instances of eyelid lymphomas reported, one study described three cases of primary lymphoma of the eyelid; another report cited a malignant lymphoma which presented as a unilateral eyelid lesion.<sup>2,3</sup>

General descriptions of lymphomas of the conjunctiva are given in the literature, but only three cases of primary conjunctival lymphosarcoma (malignant lymphoma) are reported; one involved the bulbar conjunctiva in a 72-year-old patient, who showed a characteristically good response to local radiation therapy.<sup>3,4</sup> Of 171 cases of ocular lymphoma, Reese<sup>1</sup> reported three cases of giant follicular lymphoma of the conjunctiva; of 1269 ocular cases, Rosenberg<sup>5</sup> reported two conjunctival lymphomas of the giant follicular type. Giant follicular lymphoma is a less severe form of malignancy which may be present in an inactive

state for many years before transformation to a less differentiated type. In a comprehensive series of review articles on diseases of the ocular adnexae covering 1968-1972, Boniuk and Sexton did not mention lymphoma of the eyelid or conjunctiva, either primary or metastatic.<sup>6-9</sup>

In this paper we describe a patient with bilateral conjunctival malignant lymphoma.

### Case Report

In January 1972, a 37-year-old male was referred to an ophthalmologist because of swelling of both lower eyelids of several months' duration. During this time he was treated for an allergic condition. The patient denied any other symptoms, including visual problems, fever, night sweats, or weight loss. The patient assessed his health as excellent.

Physical examination was negative except for marked fullness of the lower eyelids bilaterally. When the lower eyelids were everted, smooth, orange-colored masses bulged out from the fornices (see Figure 1). These masses were well demarcated, firm, non-tender, and fixed to the underlying conjunctivae; they measured approximately 1.5 x 0.5 x 0.5 cm. There was minimal injection of the surrounding membranes. Excessive tearing or discharge was not observed. Visual acuity remained unchanged from previous examinations. Corneal and pupillary reflexes were intact and equal. Extra-ocular muscles showed full range of action and the fundi were unremarkable.

Blood tests were normal. X-rays did not reveal mediastinal or hilar lymphadenopathy or hepatosplenomegaly. Excision biopsy of the lesions was performed under anesthesia.

---

\*From the Department of Ophthalmology, New Jersey Medical School (CMDNJ), Newark, where Dr. Cinotti is Professor and Acting Chairman. Drs. Smith and Rados are associates in that Department at the College. Dr. Cohen is Director of the Oncology Service, Newark Beth Israel Medical Center and Assistant Professor of Medicine, Department of Medicine at CMDNJ.





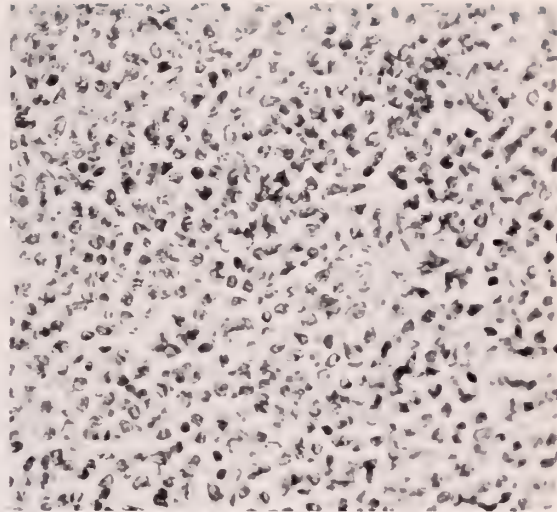
*Figure 1*—Right eye with lower lid everted showing well demarcated mass occupying most of the lower fornix. Note the swollen appearance of the left lower lid (partially shown).

The histology of the conjunctival lesions was interpreted as diffuse lymphoma, lymphocytic type, poorly differentiated. (Figures 2 and 3) Two months later the patient was referred to Newark Beth Israel Oncology Service. At this time physical examination revealed enlarged cervical, axillary, and inguinal lymph nodes. Borderline hepatosplenomegaly was suggested by x-rays. Laboratory tests showed a normal hemogram, urinalysis, blood chemistries, and a negative heterophile antibody test. Bone marrow study revealed myeloid hyperplasia and needle biopsy of an inguinal node disclosed diffuse lymphocytic infiltration. Both of these findings were consistent with the diagnosis of lymphocytic lymphoma.

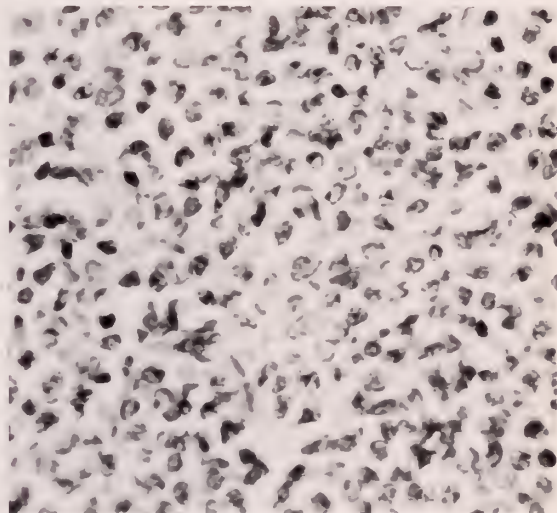
Chemotherapy was started with good initial response. The course of the illness was punctuated by increasingly severe flare-ups of nodal involvement and splenomegaly alternating with periods of partial remission. In December 1975 rapid recurrence prompted splenic irradiation. The patient is now on a regimen of Adriamycin®, Bleomycin® and Velban® and is in a stable condition. The eyelid swelling and conjunctivitis resolved soon after the original surgery and there has been no recurrence of ocular disease.

## Discussion

The striking features in this case were the uncommon site of origin of lymphoma, the bilateral presentation, and the early rapid progression of disease from focal to systemic involvement in a young, apparently healthy man. Although the conjunctiva is not a common site for lymphoma, it has an adenoid layer which contains diffuse lymphoid tissue in the fornices and bulbar portions. Thus, there is an anatomic



*Figure 2*—Low-power view of the tissue biopsy of one of the lesions. Note the monotonous sheets of cells with scanty cytoplasm and round nuclei completely obliterating the normal architecture of the conjunctival membrane.



*Figure 3*—High-power view of the same tissue as in Figure 2 showing many atypical lymphocytes, some with prominent nucleoli and mitotic figures. This picture is consistent with poorly differentiated lymphocytic lymphoma.

basis for the conjunctiva as a primary site for lymphoma, which is believed to originate in lymphoid tissue. The most common sites are the cervical, axillary, inguinal, mediastinal, and hilar lymph nodes; extranodal sites of origin are rare. The bilateral presentation of the disease would seem to favor the controversial theory of a multicentric origin of lymphoma. At any rate, it would appear to reduce the likelihood of this being an instance of metastatic

spread from a latent primary malignancy.

The rapid progress in this patient's early course may be the result of the early age of onset; the peak incidence of lymphoma is in the sixth decade. His over-all response to chemotherapy was quite satisfactory considering the relatively poor prognosis based on the original histology and clinical staging.

The appearance of the conjunctival lesions in this patient conforms quite closely to the classical description of Reese.<sup>1</sup> In particular, the orange color, well demarcated form, and the lack of dilated blood vessels on the surface of the tumor are points worth emphasizing. Eyelid swelling is not a constant feature of such tumors since it is possible for them to involve the bulbar conjunctiva as well as the fornix. Since a rapidly growing lymphoma can involve adjacent tissue whatever its primary site, it can give rise to a variety of ocular symptoms such as excessive tearing, proptosis, or sudden loss of vision.<sup>1, 3, 10</sup>

Because of the serious nature of the disease, the differential diagnosis of conjunctival tumors should always include lymphoma, especially when one or more of the characteristic features mentioned previously are part of the clinical picture. The usual list of such tumors includes conjunctival epithelial cysts, papillomas, dermoids, nevi, malignant melanoma, xanthoma (rarely without eyelid involvement), carcinoma *in situ* (Bowen's disease), and lymphoma.<sup>6-9</sup> It is particularly important for patients with histologically positive lesions to receive a thorough medical evaluation including oncologic and hematologic consultation since the histologic differentiation of lymphoma from benign forms of lymphoid hyperplasia is often difficult and controversial.<sup>3, 11</sup>

Malignant lymphoma involves the eye in one to six percent of cases, the vast majority being metastatic in origin. Only one to two percent of lymphomas of the eye and its adnexae present as the primary manifestation of the disease. The implications of this case for the ophthalmologist are clear—to maintain a high degree of awareness of this form of lymphoma and to appreciate the importance of early biopsy of suspicious conjunctival lesions with appropriate referral to an oncology service for definitive clinical diagnosis and treatment.

## References

1. Reese AB: *Tumors of the Eye*, 2nd ed. New York, Harper and Row, 1963, pp. 465-484.
2. Shields JA: Malignant lymphoma presenting as unilateral eyelid. *Mass Ann Ophthalmol* 7:689-691, 1975.
3. Walsh FB, Hoyt WF: *Clinical Neuro-Ophthalmology*, vol. 3, 3rd ed. Baltimore, Williams and Wilkins, 1969, pp. 2307-2311.
4. Lerman S: Primary lymphosarcoma of bulbar conjunctiva. *Am J Ophthalmol* 50:147-148, 1960.
5. Rosenberg SA, Diamond HD, Jaskowitz B, Craver LF: Lymphosarcoma: A review of 1269 cases. *Medicine (Baltimore)* 40:31-84, 1961.
6. Boniuk M: Eyelids, lacrimal apparatus, and conjunctiva. *Arch Ophthalmol* 90:239-250, 1973.
7. Boniuk M: Eyelids, lacrimal apparatus, and conjunctiva. *Arch Ophthalmol* 88:91-105, 1972.
8. Sexton RR: Eyelids, lacrimal apparatus, and conjunctiva. *Arch Ophthalmol* 85:379-396, 1971.
9. Sexton RR: Eyelids, lacrimal apparatus, and conjunctiva. *Arch Ophthalmol* 83:361-377, 1970.
10. Mortada A: Orbital lymphoblastoma and acute leukemias in children. *Am J Ophthalmol* 55:327-331, 1963.
11. Mortada A: Reactive lymphocytic hyperplasia of orbit, lids, conjunctiva, and lacrimal gland. *Am J Ophthalmol* 56:649-652, 1963.

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*Granular cell myoblastoma of the stomach is exceedingly rare; only nine instances have been reported in the English literature to date. The nature of this tumor is reviewed including its histogenesis, pathology and diagnosis. Although potentially malignant, its benign behavior continues to suggest conservative management, based on unhurried pathological assessment.*

# Granular Cell Myoblastoma of the Stomach\*

**Claude Abouchedid, M.D., S. S. Philo, M.D., S. H. Shetty, M.D., Trenton**

Forty-nine years after its original description by Abrikossof<sup>1</sup> granular cell myoblastoma remains a subject of controversy. While there is little agreement as to its cell of origin and precise histogenesis, no unanimity exists regarding its biochemical character; even its truly neoplastic nature has been questioned.

Granular cell myoblastoma is one of the rarest tumors to affect the stomach, thus it presents a therapeutic challenge, due to the lack of cumulative data. Although Paskin,<sup>21</sup> estimated the number of known granular cell myoblastomas to be 1000 in 1971, only nine cases involving the stomach have been reported.<sup>5, 15, 24, 25</sup> Our patient is believed to be the tenth case and to represent the first such occurrence in a caucasian, all others having been reported in negroes.

## Case Report

A thirty-one year-old caucasian female was admitted to St. Francis Medical Center on August 16, 1975; she had a one year history of epigastric distress and nausea, aggravated by eating. One month prior to admission the symptoms had become more marked and were accompanied by regurgitation of solid and liquid foodstuffs. An upper gastrointestinal series prior to admission had shown a polypoid lesion of the esophago-gastric area (Figure 1) and a duodenal ulcer (Figure 2). This constituted the basis for her hospital admission.

The patient smoked 15 to 20 cigarettes a day since age 12, but gave up alcoholic beverages a year prior to hospitalization because it caused burning pain immediately after ingestion. Physical examination was normal save for epigastric tenderness. Chest x-rays and routine laboratory studies were normal.

Fiberoptic endoscopy revealed a polypoid lesion of the esophago-gastric junction; it protruded into the stomach and measured 1.4 cm in diameter. (Figure 3). The over-

lying mucosa was slightly congested but there was no peripheral induration, ulceration, or bleeding. Biopsy specimen showed chronic inflammatory changes of the overlying mucosa. Six days later, through an anterior esophago-gastrotomy, a submucosal tumor was demonstrated on the gastric side of the esophago-gastric junction in a postero-medial location. Local excision, including the overlying mucosa, was performed. Frozen section diagnosis was granular cell myoblastoma; final pathological sections of the excised tumor confirmed the frozen section diagnosis (Figures 4, 5).

## Discussion

**Histogenesis:** Despite extensive clinical and pathological investigations, including electron microscopy and histo-chemical and biological studies, the histogenesis of granular cell myoblastoma remains uncertain.<sup>24</sup> While Abrikossof believed it to be related to the myoblast, more recent theories have included a variety of possible origins. Trauma with degeneration and regeneration,<sup>11</sup> metabolic or storage disorder,<sup>5,17</sup> neoplasm of myogenic origin,<sup>20</sup> neurological origin,<sup>3,12,13,15</sup> fibroblastic,<sup>6</sup> mesenchymal,<sup>19</sup> and even a multicellular origin,<sup>2,16</sup> have been advanced.

While the World Health Organization<sup>10</sup> has classified the tumor as of "uncertain origin," most pathologists ascribe it a neural derivation,<sup>2</sup> the precursor cell being the Schwann cells for some, and the peri-neural fibroblast or the histiocyte for others.

**Pathology:** Gastric granular cell myoblastoma presents as small, encapsulated submucosal nodules of firm uniform consistency, well demarcated from peripheral tissues, and located anywhere in the gastric wall. They have ranged from 0.8 cm to 2.5 cm in diameter.

\*From the Department of Surgery, St. Francis Medical Center, Trenton, New Jersey



*Figure 1*—Upper gastrointestinal study showing a polypoid lesion of the esophago-gastric junction.



*Figure 2*—Duodenal ulcer visible on same upper gastrointestinal study.

They are usually single, although one patient with five granular cell myoblastomas involving the gastric fundus and pars media was reported.<sup>37</sup> Multi-organ involvement was described by Paskin<sup>21</sup> in a patient who presented with separate tumor nodules in the trachea and esophagus. This occasional predilection of granular cell myoblastoma for multiple tissues raises the possibility of a "specific provoking agent," of infectious or metabolic nature, being released by the tumor.<sup>24</sup> In support of this view, virus-like particles have been identified on electron microscopy. Microscopically the tumor is made of irregular, polyhedral cells, arranged in bundles, cords, or sheets. The cytoplasm varies from pale to intensively eosinophilic and granular, with a loose fibrous stroma (Figures 4 and 5).

Abrikossof<sup>1</sup> distinguished four varieties based on microscopic appearance:

*Type One:* Characterized by the presence of myoblasts without striation.

*Type Two:* Characterized by myoblasts with longitudinal or cross striations imperfectly developed in the margin of the cell.

*Type Three:* Characterized by markedly hypertrophic myoblasts, multi-nuclear and often syncytial with possible striation.

*Type Four:* Characterized by atypical myoblastic sarcoma cells, with marked pleomorphism, quoted by Abrikossof after von Meyenburg's case. Most reviewers have felt that the type should be classified as rhabdomyosarcoma. In fact, it has helped create much confusion on the issue of the potential for malignancy of granular cell myoblastoma.



*Figure 3*—Endoscopic view of submucosal tumor at the esophago-gastric junction.

Malignant transformation which is rare, occurs in one to two percent for types one, two, and three.<sup>23</sup> Ross,<sup>22</sup> in 1951, following a review of the literature, identified only four unequivocal cases of malignancy, none of which affected the stomach. Four years later Gamboa,<sup>14</sup> found ten nongastric malignant granular cell myoblastomas and divided them into clinically malignant—histologically benign and clinically malignant—histologically malignant. Colbey,<sup>7</sup> in 1963 reviewed 400 cases, to find only fourteen malignancies; the subcutaneous tissue was the primary site in nine, and the breast, eyelid,

bladder, biceps, and colon each were the site of one of the remainders.

If malignant, the tumor has more tendency to lymphatic spread, but can metastasize also by way of the blood stream. When metastatic, it has a tendency to be very invasive.<sup>8</sup> No hormonal activity has been demonstrated so far in any of the reported tumors.

Not one of the known cases of gastric granular cell myoblastoma has been malignant.<sup>4</sup> Caution should therefore be exercised in the selection of the surgical procedure. Because the tumor cells may extend between muscle bundles,<sup>5</sup> and because of the tendency of the tumor to produce a pseudoepitheliomatous hyperplasia of the overlying epitheliums,<sup>18</sup> a diagnosis of carcinoma associated with granular cell myoblastoma should be weighed very carefully before institution of cancer therapy.

*Diagnosis:* The diagnosis of granular cell myoblastoma of the stomach is made at laparotomy or autopsy. Symptoms include

intermittent or continuous epigastric pain, anorexia, nausea, and vomiting. Four of the nine previously reported patients had peptic ulcer symptoms.<sup>5</sup> (Our patient also had a duodenal ulcer.) Roentgenograms of the stomach, reveal a polypoid lesion compatible with adenomatous polyp, lymphoma, leiomyoma, lipoma, melanoma, leiomyoblastoma, leiomyosarcoma, metastatic carcinoma, angioma, fibroma, neurofibroma, and others. Fiberoptic endoscopy aids the diagnosis by revealing the characteristics of a submucosal tumor, usually spherical with a broad base and a diffuse transition to normal mucosa; "bridging folds" are sometimes visible. Differentiation between each variety of submucosal tumor is usually difficult, except for those presenting particular characteristics, e.g., umbilication in the case of aberrant pancreas. Endoscopic biopsy is frequently unsuccessful since it is difficult to obtain tumor tissue for a sample; caution should be exercised as severe bleeding may ensue.

*Management:* When the diagnosis of gastric granular cell myoblastoma is made at surgery



Figure 4—Microscopic section of cardia with neoplasm in submucosal location.

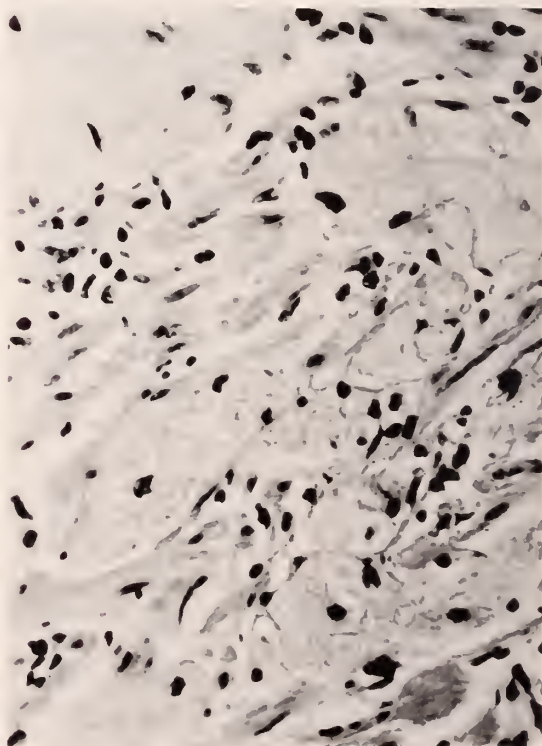


Figure 5—High power view showing "granular" cytoplasmic appearance of tumor cells.



by frozen section, management decision confronts the operator. The choice of the procedure depends on present knowledge of the behavior of this potentially malignant tumor. Conservative management is advisable since none of the nine previously reported cases showed evidence of carcinomatous degeneration. While five of the patients were treated by local excisions, four received partial gastrectomies.

We subscribe to the view of Aston,<sup>4</sup> that the immediate approach should be based on the gross appearance of the tumor. Unless it appears grossly to invade adjacent structures, wide local excision is sufficient. The margins of resection must be clear, however, because of the possibility of local recurrence. One should keep in mind the tendency of this tumor to form syncytial cords and sheets and to stimulate epithelial hyperplasia, which may prompt a misleading diagnosis of malignancy at frozen section. Permanent sections showing atypical cells, mitoses, disorganized patterns, or other evidence of malignancy should be a prerequisite to radical surgery. Wide-spread lymph node metastases attests to the potential of this tumor for rapid dissemination. Judging from the usual behavior of malignant granular cell myoblastoma, the presence of positive nodes, portends death within five years of diagnosis.<sup>14</sup> Surgery is presently the only therapeutic avenue; radical resection, with en bloc lymph node dissection, must be made whenever possible. Radiation therapy has been used, but to no avail in the treatment of this tumor; the value of chemotherapy is presently unknown.<sup>9</sup>

## References

1. Abrikossov A: Uber Myome, ausgehend von der gnergestreipten wiakurlichen Muskulatur. *Virchow Arch Pathol Anat* 260:215, 1926.
2. Alkek DS, Johnson WC, Graham JH: Granular cell myoblastoma—A histological and enzymatic study. *Arch Dermat* 98:543, 1968.
3. Ashburn LL, Rodger RC: Myoblastomas neural origin. *Amer J Clin Path* 22:440, 1952.
4. Aston SJ, Tömkins RK: Granular cell myoblastoma of stomach. *Ann Surg* 177:228, 1973.
5. Azzopardi JG: Histogenesis of the granular cell myoblastoma. *J Pathol and Bact* 71:85, 1956.
6. Coggins RP: Granular cell myoblastoma of the common bile duct. *Arch Path* 54:398, 1952.
7. Colberg JE: Granular cell myoblastoma. *Int Abst Surg* 115: 205, 1962.
8. Crawford ES, DeBakey ME: Granular cell myoblastoma—Two unusual cases. *Cancer* 6:786, 1953.
9. Elias EG, Valenzuela L, Pickerin JW: Granular cell myoblastoma. *J Surg Oncol* 2:33, 1970.
10. Enzinger FM, Lattes R, Torloni H: Histological typing of soft tissue tumors. *J World Health Organization*, Geneva, Switzerland 24:39, 1969.
11. Ewing J: *Neoplastic Diseases*, 4th ed. Philadelphia, Saunders, 1940, pp 247-248.
12. Fisher ER, Wechsler H: Granular cell myoblastoma—A misnomer. *Cancer*; 15:1936, 1962.
13. Fust JA, Custer RP: Granular cell myoblastomas and granular cell neurofibromas: Separation of neurogenous tumors from the myoblastic group. *Amer J Path* 24:674, 1948.
14. Gamboa LG: Malignant granular cell myoblastoma. *Arch Pathol* 60:663, 1955.
15. Goodman ML, Gottlieb LS, Zamcheck N: Granular cell myoblastoma of stomach and colon. *Amer J Dig Dis* 7:432, 1962.
16. Krieg AF: Malignant granular cell myoblastoma. *Arch Pathol* 74:251, 1962.
17. Leronx R, Delarue J: Sur trois cas de tumeurs a cellules granuleuses de la cavite buccale. *Bull Ass Franc Cancer* 28:427, 1939.
18. Ma WJ: Myoblastoma: Report of a case with review of 287 cases collected from the literature. *Chin Med J* 70:34, 1952.
19. Moscovic EA, Azar HA: Multiple granular cell tumors ("myoblastomas"). *Cancer* 20:2032, 1967.
20. Murray MR: The cultural characteristics of three granular cell myoblastomas. *Cancer* 4:857, 1951.
21. Paskin DL, Hull JD, Cookson PJ: Granular cell myoblastoma—A comprehensive review of fifteen years experience. *Ann Surg* 175:501, 1972.
22. Ross RC, Miller TR, Foote FW Jr: Malignant granular cell myoblastoma. *Cancer* 5:112, 1952.
23. Rothchild TP, Crary RH: Granular cell myoblastoma—A report of five cases. *Ann Surg* 137:530, 1953.
24. Strong E, McDinnitt R, Brasfield R: Granular cell myoblastoma. *Cancer* 25:415, 1970.
25. Svejda J, Horn V: Disseminated granular cell pseudotumor: So-called metastasizing granular cell myoblastoma. *J Path Baet* 76:343, 1958.

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**SIDE EFFECTS** No serious side effects have been reported. In sublingual therapy, a tingling sensation (like that of nitroglycerin) may sometimes be noted at the point of tablet contact with the mucous membrane. If objectionable, this may be mitigated by placing the tablet in the buccal pouch. As with nitroglycerin or other effective nitrites, temporary vascular headache may occur during the first few days of therapy. This can be controlled by temporary dosage reduction in order to allow adjustment of the cerebral hemodynamics to the initial marked cerebral vasodilation. These headaches usually disappear within one week of continuous therapy but may be minimized by the administration of analgesics.

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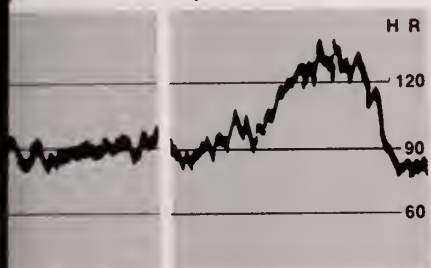
# Sex and the heart patient:

A film every doctor should see.

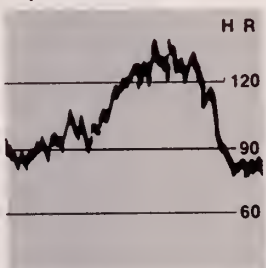
The energy cost of sex to the heart is relatively modest.

Over 80% of post-coronary patients ultimately resume sexual activity without serious risk. Hellerstein and Freedman demonstrate that mean maximal heart rate during orgasm in spouse (as opposed to extramarital sex) in 14 post-infarct patients is lower than that during usual occupational activity.

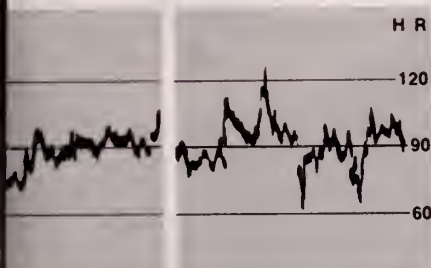
Representations below of actual ECG readings of an attorney, post-infarct, illustrate the point:



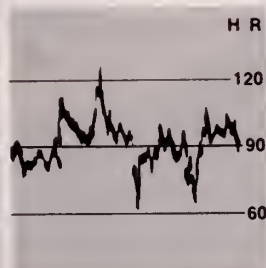
A. Working in office (about 90 beats/min)



B. Confrontation in judge's chamber (about 125 beats/min)



C. Pre-orgasm sex activity (about 90 beats/min)



D. Peaks at orgasm (120 beats/min)



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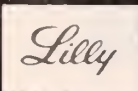
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*It is now possible to provide total care to the multiply injured trauma victim. This care is based in a trauma center, the hub of a system of EMS care, which also includes transportation, communications, other specialty referral centers, research, and education. The trauma center must include certain unique features, and its staff must be specially trained.*

# Trauma Center

## A New Concept for the Delivery of Critical Care

R Adams Cowley, M.D., Baltimore

The knowledge and equipment now are available to provide excellent care for trauma victims, who have a right to the best medical care, according to the state of the art and not according to location, extent, or severity of injury. Our task is to pull together the available resources in organized, integrated systems of care for the country's most critically ill and injured.

In Maryland, we have been involved for years in doing just that. Our experiences at the Maryland Institute for Emergency Medicine support the need to develop a new concept of trauma centers.

### Goals

The goals of a trauma center are to provide excellent care at all levels, to develop standards of therapy through research and education, to disseminate new knowledge in trauma care, and to provide care systems for the community.

### The Need

Accidental injury is the leading cause of death among all persons aged one to 38 years. Each year more than 60 million people are injured. Of these, more than 115,000 die, 14 million require bed care for a day or more, and 400,000 suffer lasting impairment at a cost of \$5.4 million in medical fees and hospital expenses and over \$13 billion in lost wages.<sup>1</sup> One of every eight beds in a general hospital is occupied by an accident victim.<sup>2</sup> Furthermore, accidents take the lives of young, healthy

individuals who otherwise could expect to enjoy long and productive lives. In addition to the human loss, the cost to society is over \$41.5 billion a year.<sup>1</sup>

Many of these lives could be saved with prompt, aggressive emergency medical care provided through a pre-planned, well-organized system. The cooperation and participation of many people and resources in the community must be focused on the emergency victim, so we can offer all citizens the best emergency care science can provide, and consequently decrease death and disability due to life-threatening medical emergencies.<sup>3</sup>

### Deficiencies

Major deficiencies exist in current emergency medical care.<sup>4</sup> Despite increasing support for the categorization of hospitals, it is still common practice throughout the country to transport the trauma victim to the nearest hospital, regardless of its capability to manage severe injury. The patient is either insufficiently treated or the hospital decides to transfer the patient to another hospital, resulting in a loss of precious time.

Geographic factors compound this delay. Emergency medical services are the least available in rural areas where most motor

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\*Read before the Section on Emergency Medicine, 211th Annual Meeting, the Medical Society of New Jersey, May 15, 1977, Atlantic City. Dr. Cowley is Director, Maryland Institute for Emergency Medicine, Baltimore.

vehicle accident deaths occur.<sup>4</sup> The wait for an ambulance is longer because of greater distances, and the nearby medical facilities are likely to be small and less sophisticated. Most rural and urban hospitals are not prepared with facilities, staffing, or therapeutic philosophy to manage the critically injured patient. In many teaching hospitals, the trauma victim is met by the least-experienced house staff physician, the intern, who is inadequately prepared to make the first, aggressive decisions that may be life-saving. In many community or rural hospitals the patient may be met only by a nurse, who then must search for proper assistance.

Treatment is further compromised by inadequate facilities, by harassment and pressure of a busy emergency room at times accidents most frequently occur, and by unavailability of senior staff.<sup>5</sup> The critically ill patient frankly is unwelcome in many hospitals because of the ensuing disruption. These problems in current care reinforce the need for trauma centers geared to these patients.

### The Trauma Center

The trauma center must exist to provide the best treatment science can offer to the worst critically ill and injured patient. At the Maryland Institute for Emergency Medicine these include those with:

- severe injuries to two or more body systems
- head and spinal cord injuries
- cardiac and major vessel injuries
- uncontrolled shock from any cause
- multiple injuries with complications such as shock, sepsis, respiratory, cardiac and liver failure, alcohol and drug overdose
- severe facial and eye injuries
- burns
- gas gangrene; carbon monoxide and other poisoning

A trauma center must be a first contact, combined emergency room and intensive care unit, with its own operating rooms always prepared on minimal notice to admit and immediately to treat the critically injured emergency patient. There is no waiting. The patient on arrival is usually undiagnosed and untreated, with his survival at stake. Experienced personnel must be able to provide resuscitation, diagnostic and therapeutic measures for the most acute

situation and continue such care until the patient's condition is stabilized. The patient cannot wait for this care nor can he be moved. All necessary services, including blood bank, radiology, and laboratory, must revolve around him.

### Systems of Care

A trauma center cannot exist in a vacuum. It must serve as the hub of a system of stratified care, in order to overcome the current deficiencies in the delivery of emergency medical care.

In Maryland, a statewide emergency medical services was established in 1973 with the creation of the Division of Emergency Medical Services (DEMS), a service organization, and the Maryland Institute for Emergency Medicine (MIEM), formerly the Center for the Study of Trauma, which is the trauma center. DEMS works with the providers of emergency care throughout the state, and MIEM serves as resource center, developing and disseminating new concepts in therapy, teaching, research, management and systems engineering applied to EMS problems.

### Regionalization

Maryland established five regions, based on jurisdictional patient-flow patterns, medical capability and availability of resources, and geographic factors. In each region, a council composed of consumers, professionals, provider institutions, and government representatives determines needs and resources and does initial planning. The councils ensure the compatibility of equipment, standards, and procedures within the system and between adjacent systems.<sup>3</sup> Improvement of local hospital capabilities is also the responsibility of regional councils. This ensures that patients from the region will be directed to the facility that can provide appropriate care.

### Relationships with the Trauma Center

Through the statewide EMS system and the regional councils, the trauma center, MIEM, has links with the public, physicians, hospitals, and communities throughout the state. DEMS



conducts public information and education programs for citizens to explain how the system and its components, including MIEM, relate to them, and how to access the system. The medical community is involved through the regional and other councils. MIEM also contacts physicians directly, to explain its function, the type of patient appropriate for referral, the method of interhospital transfer and available consultation. Continuing education programs for physicians in the state further reinforce the relationship. Interhospital transfer agreements also are worked out through the EMS councils. Through government representation on these councils jurisdictional obstacles are overcome.

### Specialty Referral Centers

To assure that the patient arrives at a facility most able to treat his injuries, a system of specialty referral centers has been established in Maryland. In addition to the hub trauma center, MIEM, other centers with further specializations participate in the system. The Johns Hopkins Hospital Pediatric Emergency Trauma Center provides services for children similar to those for adults at MIEM, but tailored to meet the specific and different needs of children. The Baltimore City Hospitals' Kiwanis Burn Unit and the Washington Hospital Center Burn Unit provide the medical personnel, facilities, and rehabilitation required by burn victims. A State Intensive Care Neonatal Program at Baltimore City Hospitals, University of Maryland Hospital, and Johns Hopkins Hospital manages critically ill and premature newborns referred from all over the state. A Hand Unit at Union Memorial Hospital has special microsurgical facilities and personnel for repair and reimplantation of severely injured and severed hands and arms. Because of the frequency and severity of central nervous system injuries, the necessary specific resources are being assembled to form an Acute CNS Injury Unit at MIEM to deal with these difficult cases.

### Transportation

A rapid, effective system must exist to bring the most critically ill and injured patients, who cannot be managed adequately in the regions,

to the trauma and specialty referral centers. The first 60 minutes (the "Golden Hour") following an accident often determine whether a patient will live or die. On-site resuscitation, triage, communication and transportation with care enroute must be available to complement definitive care at the trauma center.<sup>6</sup> Indeed, the trauma center's program begins at the scene of an accident and during transportation to the center.

Maryland's volunteer and paid ambulance and rescue squad system and the Maryland State Police Med-Evac Helicopter system cooperate to provide initial triage and rapid transportation to the appropriate care facility. The helicopter system has proved very effective in transporting patients from all over the state to the trauma center within the "Golden Hour." Local ambulance teams, who usually reach the scene first, initiate resuscitation and request a helicopter transfer when it is determined the patient requires the care of the trauma or a specialty center. The use of the helicopter system precludes extensive treatment at the scene or enroute. We have found that the time gained in getting the patient to the definitive care of the trauma center is more valuable than complicated resuscitation at the scene.<sup>4</sup>

### Communications

A statewide communications center (SYSCOM) coordinates Med-Evac helicopter transports, forewarning the trauma center of a patient's arrival, patient status, and extent of injury. Thus, the emergency patient arrives "by appointment." This assures that the appropriate personnel and equipment will be assembled and waiting when the patient arrives. Through SYSCOM, consultation with traumatologists at MIEM is available to physicians throughout the state.

A newly established communications system will link the scene of an emergency, ambulances, hospitals, specialty referral centers, central alarms, and Med-Evac helicopters without disturbing present ambulance dispatch methods and equipment. Services began this July.

## Operation of a Trauma Center

Embedded in this system of emergency care delivery, MIEM, as the trauma center, retains the major responsibility for care of the critically injured patients from the whole state, in addition to its education, research, and resource functions.

*Basic Philosophy of Treatment*—The basic philosophy is total preparedness for any life-threatening injury. All patients are assumed to be dying and much of the "Golden Hour" for total stabilization has passed. Thus the fight for survival in the Institute begins on direct admission. Treatment begins before diagnosis—a necessary break with tradition. Resuscitation and stabilization have priority. If one awaits an accurate diagnosis, many of these victims will die.<sup>6</sup>

Standard, established treatment protocols—rapid body assessment, endotracheal intubation, continuous positive pressure ventilation, circulatory support, and early, aggressive surgery—provide a planned approach to resuscitation. Each team member has pre-assigned tasks. The use of blood component therapy and uncrossmatched blood,<sup>7</sup> upright chest x-ray, carotid angiogram,<sup>8</sup> and abdominal lavage<sup>9</sup> are standard.

## Trauma Center Requirements

Components of MIEM include:

*Separate Admitting Area*—Patients are admitted directly to our admitting area, bypassing the already overburdened emergency room. The patient is seen and treated immediately by the trauma staff. Initial examination, establishment of an airway, and drawing blood samples are done as needed. Emergency maneuvers and penetrations for monitoring are made, clothing removed, x-rays taken, casts applied, minor surgery performed, and burns cleaned and dressed.<sup>10</sup>

The whole area has the facilities to admit five patients simultaneously. Each subarea is a small operating room. The area contains a blood bank refrigerator, which stores uncross-

matched blood and blood substitutes; outlets for oxygen, air, suction, and nitrous oxide for anesthesia; electrical and emergency power outlets; electrocardiography; a ventilator; intubation equipment; a Steadman pin set; crash cart; defibrillator; Ambu bag; minor surgery set; and an orthopedic cart. A teleprinter connected to the clinical laboratory and an intercom system allow communication with the lab. A portable x-ray unit and darkroom complete the area.

*Operating Rooms*—Most trauma victims with multiple injuries cannot survive without immediate surgery. A delay of minutes or hours while the operating room is prepared and the personnel assembled can be fatal. Therefore, 24-hour, immediate access to a fully staffed and fully equipped operating room is essential. Two rooms are best—one reserved at all times for emergency surgery and the other for scheduled follow-up operations.

The rooms should be as close as possible to the admitting area to avoid dangerous delays in getting the patient to surgery. They should be large enough to accommodate the personnel and equipment to perform several procedures simultaneously.

*Critical Care Recovery Unit (CCRU)*—For this ultra-sophisticated unit, we have found that a wheel design with beds located at the periphery of a central nursing station hub is the best way to economize human energy for nursing care. Our unit has 12 cubicles, separated by large windowed partitions, around the perimeter. Two are isolation cubicles. The central island is a raised podium, from which each cubicle and the central monitoring system are visible. The open end of the cubicles allow access for bulky equipment—ventilators, hypothermia equipment, x-ray equipment, and so on. The partitions and raised island partially obstruct the view of other patients. The partitions also help reduce infection and noise.

In each cubicle, equipment is attached to the wall and ceiling to keep floor space around the bed free. All the cubicles are self-contained, completely equipped and supplied. Current

patient records are kept nearby.<sup>7</sup> Mounted on an overhead shelf above each patient is a total physiologic monitoring system with its own controls and alarms. Each separate system is attached to a central system located in the central island. A CRT terminal ties into the computer system and provides analog and digital readouts and trend information on each patient.

The central island platform has writing space, racks for patient charts, telephones, shelves and drawers, a computer terminal and the central monitoring system. It is large enough for several people to gather. The outside of the raised platform has storage space for intravenous solutions and other frequently used supplies, which are restocked regularly. A medicine area at one end includes a refrigerator, blood bank refrigerator, and narcotics cabinet.

*Trauma Intensive Care Unit*—Located adjacent to the CCRU, the stepdown ICU has three four-bed units with glass partitions, a raised nursing station and complete patient monitoring and computer equipment. There are 28 beds for further stepdown care.

*Acute CNS Injury Unit*—An acute CNS injury unit is scheduled to open soon to provide the specific care needed by patients with such injuries. Although CNS patients have been treated all along, this new unit will group these patients with the required facilities, equipment and personnel for more efficient, effective care. Not a long-term rehabilitation unit, it will provide total acute care to give patients the best chance for recovery of function. An acute area with six completely monitored (including intracranial pressure) beds will be supplemented by six beds in three rooms for less intensive care and an isolation cubicle.

*Acute Clinical Laboratory*—Essential to the operation of the trauma center, this 24-hour laboratory provides blood gas analyses, electrolyte and coagulation studies, and so on. It is near patient care areas and is able to furnish immediate findings to attending physicians.

*Computer System*—A computer system supports comprehensive patient care and monitoring by central collection and coordination of all pertinent data generated by each patient. It calculates the patient's critical physiological indices in order to alert the staff to possible abnormalities or failure, and it ties in to metabolic sensory equipment. The system automatically saves and displays selected readings and provides for review and correlation of patient data to evaluate treatments, diagnosis, or new indices, and to provide better patient care.

*Other Facilities*—Other physical components of the center include an on-call physicians' room, a nurses' lounge, utility rooms, storage space, and a visitors' lounge.

### Ancillary Services

*Radiology*—Portable radiology equipment is used in all patient areas to provide on-site radiologic studies for diagnosis and follow-up, including contrast media studies. Radiology services are provided through arrangement with the University Hospital.

*Blood Bank*—Uncrossmatched blood and blood components are available in the admitting area. A supply of blood is kept in the CCRU. The trauma center cooperates with the adjacent University Hospital's Blood Bank for the large amounts of blood and blood derivatives required.

*Psychosocial Services*—Psychosocial support for patients and their families is provided by an interdisciplinary staff during the patient's stay in the center. The staff also assists patients and families with discharge planning. Consultation is available from the School of Medicine's Department of Psychiatry. The staff also cooperates with the School of Social Work and Community Planning to provide educational experiences for students.

*Rehabilitation Medicine*—Rehabilitation begins at the time of injury. The care a patient receives immediately will affect his long-term recovery and disability. This program is



managed in conjunction with the Department of Rehabilitation Medicine, continuing throughout definitive care and on to long-term rehabilitation elsewhere upon discharge from our unit.

### Patient Flow

Facilitation of patient flow is important in a trauma center. Continuity of care is essential as the patient's condition improves and he progresses through various treatment steps toward recovery. Without smooth channeling of patients, the trauma center becomes congested with extended care cases and is unable to meet its primary responsibility to the critically injured.

In our center, the patient is admitted directly to the admitting area where he is resuscitated and stabilized. Emergency surgical procedures may be performed in this area, but if possible, the patient is moved to the adjacent operating room for surgery. After primary surgery, the patient is taken to the Critical Care Recovery Unit, where the average stay is five and a half days.

After the patient has progressed past the need for the superintensive care and observation, he is transferred around the corner to the Intensive Care Unit, where he may stay for five to ten days. He proceeds to one of the 28 stepdown beds for continuing special care. He is then discharged to a general hospital bed, a rehabilitation facility or home. The patient may return to the MIEM clinic for follow-up.

Patients with central nervous system injuries are transferred to the CNS Unit after admission and initial surgery. The stepdown beds in the unit are the next stage, followed by referral to a rehabilitation facility or community hospital providing rehabilitation services.

### Personnel

Trauma centers require seasoned clinicians, nurses, and specialists. At MIEM, all physicians, nurses, and paraprofessionals undergo intensive orientation in all phases of management of major multiple trauma problems. The program is completely staffed around-the-clock

and the operating rooms, admitting areas and laboratories are immediately available to receive any type of critical care or surgical problem.<sup>6</sup>

*Medical Director*—One medical director has full-time responsibility for the operation of the unit. The individual should be experienced in resuscitation and cardiorespiratory care and be capable of all clinical decisions about procedures and therapy. He maintains control of each patient in the center.

*Specialists*—The complicated problems the trauma patient presents demand the attention of numerous specialists, including traumatologists, anesthesiologists experienced in critical care medicine, orthopedic surgeons, neurosurgeons, thoracic surgeons, plastic surgeons, radiologists, infectious disease specialists, urologists, nephrologists, and therapists in respiratory care and physical medicine. Those involved in the primary management of the trauma patient are on the full-time attending staff of the trauma center. Others serve as consultants, and are readily available. In addition to providing consultants for patient care, most departments within the University's School of Medicine use the resources of the trauma center for training and research.

*Team Concept*—At our trauma center, we use teams to deliver care. There are four teams with a traumatologist, critical care anesthesiologist, and trauma and anesthesiology residents. Each 24 hours, one team is on duty, another is on call, a third is able to be called in, and another is off duty. The schedules for these teams rotate. Each team is directed by a leader who retains responsibility for the team's patients, but all members provide input. The team that is on duty manages the resuscitation and stabilization of the patients admitted that day. If there is an unusually large number of admissions, the second and possibly the third teams are called in. The team leader continues to direct the patient's care in the CCRU.

Specialty teams perform several surgical procedures under one anesthetic.

**Nursing**—Our nursing branch is subdivided into five groups, according to the patient areas—the admitting area, the operating rooms, the CCRU, the ICU, and the CNS Unit. Nurses specialize in one area, although they have the training and knowledge to assist in other areas when needed.

In the CCRU and the ICU, the primary nursing system is used. When a patient is transferred into the unit, a primary nurse is assigned to him and assumes overall responsibility for his nursing care while in the unit. She cooperates with the team leader.

### Teaching

Any specialized center in a field of emerging knowledge has a responsibility for education. This is true in a trauma center where the relatively new specialties of traumatology, critical care medicine, critical care nursing, and primary nursing play major roles. Fellowships are offered in these fields.

Residents in various medical and surgical specialties regularly rotate through the center. Cooperative agreements with several hospitals provide their residents with unique experience in trauma care.

Intramural education includes daily combination bedside and sitdown rounds, twice weekly lectures, a weekly mortality conference, a monthly journal club, and two clinical conferences a month.

Extramural education in trauma is provided through programs for physicians and nurses from the whole state, both at the center and in local hospitals. In addition, MIEM cooperates in training programs for paramedics—emergency medical technicians and cardiac rescue technicians.

### Research

Because of its unique patient population and the necessity for innovative treatment, a trauma center must be involved in research and the dissemination of new knowledge. Research proceeds on both clinical and basic laboratory levels.

Biochemists in our Research Laboratory study the pathophysiology of the cell in shock, the mechanisms of injury, cell death, and organ failure. The involvement of hormones such as insulin and prostaglandins, the function of mitochondria, and metabolic aberrations in critical injury are being scrutinized.<sup>11-15</sup>

Researchers in an immediate autopsy program obtain biochemical, ultrastructure and microbiological data from fresh tissue—within five minutes of death. The analysis of these data, using the electronmicroscope, offers a means of correlating clinical information with data on the status of membranes and organelles and assessing therapy.<sup>16</sup>

Clinical studies include review of clinical material and evaluation of therapies.<sup>17-21</sup> We are developing an index to predict the clinical course of trauma victims.<sup>22</sup> Nursing research also is progressing in a number of directions.<sup>23</sup>

The computer system, of course, assists in data storage, retrieval, and structuring for many research projects. In addition to these uses, the computer system itself is being studied for future applications.

### Future Directions

The use of computer systems in patient care is, in fact, one example of advances in patient care that will change the trauma centers of the future. The storage and retrieval of demographic, biochemical, physiologic, and laboratory study data for efficient accessibility at the bedside, the on-line measurement of physiologic parameters, and the organization of these data will give physicians extensive valuable information upon which to base decisions about therapy. The computer system also will assist physicians and nurses by notifying them of the occurrence of critical values, including automatically computed indices. These indices increase knowledge of patient risk by drawing upon past experience and upon structural relationships among measured variables. The computer also will be able to “recommend” action by physicians by carefully developed clinical algorithms.

The infusion of blood, fluids, drugs, and nutrients can be controlled by the computer, which is an ideal tool to balance all factors and optimize the objective, allowing for smoother response with less risk to the patient.

Of course, the use of the computer system for archival storage of data for other research will continue to be very important, because continuing progress in patient care will depend upon future research.

As the trauma center concept matures, more university-affiliated centers will become regional resource centers for research and education. There still will be a need for satellite trauma centers dedicated to patient care and direct service, without the costly teaching and research components.

In the future, research in the many aspects of delivery of trauma care—laboratory, clinical, educational, and systems of care delivery—must be integrated into a common, multidisciplinary goal. To accomplish this, the concept of several regional resource emergency medical service institutes across the country is gaining support at the national level. The institutes would dedicate experts and resources to the mission of gaining and disseminating knowledge in all facets of trauma care delivery. As awareness of the impact and value to society of such concentrated efforts grows, federally supported regional EMS institutes are likely to be a future reality.

## References

1. *Accident Facts*, National Safety Council, Chicago, Illinois, 1974.
2. *Accidental Death and Disability: The Neglected Disease of Modern Society*. Committee on Trauma and Committee on Shock, Division of Medical Sciences, National Academy of Science-National Research Council, 1966.
3. Cowley RA: A total emergency medical system for the state of Maryland. *Md State Med J* July, 1975.
4. Cowley RA, Hudson F, Scanlan E, Gill W, Lally RJ, Long W, and Kuhn AO: An economical and proved helicopter program for transporting the emergency critically ill and injured patient in Maryland. *J Trauma* 13:1029, 1973.
5. Cowley RA: A study of shock and trauma in man utilizing the resources of a clinical shock trauma unit. *Md State Med J* March, 1967.
6. Cowley RA: The resuscitation and stabilization of major multiple trauma patients in a trauma center environment. *Clin Med* 83:14, 1976.
7. Gill W, Champion H, Long W, Austin EA, and Cowley RA: Volume resuscitation in the critical major trauma. *J Roy Coll Surg* 20:166, 1975.
8. Ayella RJ: Combined thoracic aorta and right carotid artery angiography in trauma. *Angiography* 26:564, 1975.
9. Gill W, Champion H, Long W, Jamaris J, and Cowley RA: Abdominal lavage in blunt trauma. *Br J of Surg* 62:121, 1974.
10. Cowley RA and Scanlan E: Trauma unit: Design criteria. Chapter in *Thoracic Trauma*, Yearbook Medical Publishers, Chicago. In press.
11. Vitek V, Vitek K, and Cowley RA: Lactosuria—A new metabolic feature of severe cerebrocranial trauma. *Clin Chim Acta* 58:109, 1975.
12. Gill W, Vitek V, Conn A, and Cowley RA: Excretion of cyclic AMP in post-traumatic acute renal failure. *Clin Res* 22:340, 1974.
13. Vitek V, Vitek K, and Cowley RA: Excretion of carbohydrates in seriously injured patients. *Amer Surg* 40:110, 1974.
14. Markelonis G and Garbus J: Prostaglandins and cell injury. *Prostaglandins* 10:1087, 1975.
15. Vitek V, Gill W, Conn A, Lang D, and Cowley RA: The effect of trauma on urinary cyclic AMP in children of different ages. *Clin Chim Acta* 70:227, 1976.
16. Trump B, Valigorsky J, Jones R, Mergner W, Garcia, J, and Cowley RA: The application of the electron microscopy and cellular biochemistry to the autopsy: Observation on cellular changes in human shock. *Human Pathol* 6:409, 1975.
17. Gill W, Champion H, Long W, and Cowley RA: The evaluation of blunt abdominal trauma. *Md State Med J* 24:69, 1975.
18. Shin B, McAslan TC, and Ayella RJ: Problems with measurements using the Swan-Ganz catheter. *Anesthesiol* 43:474, 1975.
19. Shin B, McAslan TC, Hankins JR, and Ayella RJ: Management of lung injury resulting from blunt chest trauma. (Abstract) *Crit Care Med* 4:126, 1976.
20. Gill W, Champion H, Angus P, McCloskey S, and Cowley RA: Central venous pressure monitoring with positive end expiratory pressure. *J Roy Coll Surg* 20:163, 1975.
21. Byrnes DP, Russo GL, Ducker TB, and Cowley RA: Sacrum fractures and neurologic damage. *J Neurosurg* In press.



22. Cowley RA, Gill W, Sacco W, Champion H, Long W, Copes W, Goldfarb M, and Sperrazza J: A prognostic index for severe trauma. *J Trauma* 14:1029, 1974.

23. Abbot NK and Walrath JM: Catheter line infection study. *Proceedings, Second Eastern Conference on Nursing Research*. In press.

22 South Greene Street, Baltimore

### Risks of Breast Cancer Weighed for Patients

"What are my chances of getting breast cancer?" This is the question that most women ask their doctor some time during their lives.

In the July 25 issue of *JAMA*, Theodore C. Bernstein, M.D., cancer specialist of the Scripps Clinic and Research Foundation, La Jolla, California, offers some guidelines to physicians to help them answer the question.

In one of every 15 women, breast cancer will develop, Dr. Bernstein says. Women with an early menarche and those with menopause at 50 years and older have about 1½ times greater risk than those having natural menopause under the age of 45 years. Removal of the ovaries in a woman aged 40 years or less decreases the risk about 50 percent. Risk is tripled when first pregnancy occurs after the mother is 35 years of age, he says. Women who have never married are at increased risk. Women who are fat have increased risk.

Birth control pills and hormones given after menopause have been implicated in cancer, but the relationship is not established, Dr. Bernstein says. However, there is enough of an association to suggest that estrogens should not be used by high-risk patients.

Prior cancer of the uterus, ovary, or colon increases risk of breast cancer. The most com-

mon premalignant lesion is cancer of the opposite breast. One in ten of those having cancer in one breast will develop cancer in the other.

Risk of breast cancer varies geographically. In Japan women have a much lower rate than in America. When Japanese women migrate to America, the incidence increases after several generations. Exposure to irradiation by mammograph "probably increases the risk, especially in premenopausal women."

Heredity plays a major role in breast cancer risk. Children of women having bilateral breast cancer may have a 50 percent chance of having the disease. Period of highest risk in women is between the ages of 20 and 40 years. But in women with no heredity risk, the probability of breast cancer development rises with advancing age. "Indeed, age is probably the most important factor influencing the development of breast carcinoma," Dr. Bernstein says.

He concludes: "In advising women about their chances of getting breast cancer, a physician should not lean too heavily on the statistics of risk. One cannot make predictions about a person based on statistics. It is wise to advise every woman to pay close attention. 'Examine yourself each time you bathe and report to me without delay any irregularity you encounter.'"

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Pyridoxine HCL (B-6) ..... 10 mg.

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### British National Health Service in 1977 — Part III

#### Patient Reaction

Informal discussion about the British National Health Service elicited a number of subjective responses from patients and relatives:

1. They like the idea of having a general practitioner available to them through NHS.
2. The minimal cost of prescription drugs, glasses, and dentures is a great asset.
3. Knowledge that they will not be wiped out financially by an overwhelming illness provides security.
4. Recognition that serious acute illness requiring immediate hospitalization will be taken care of is a comfort.

Not having been exposed to disease detection procedures, health education, and preventive medicine practices, such as complete physical examinations, the British do not seem to miss these things. They tolerate the long waiting periods in the doctor's office and the inordinate delays for consultations with specialists and admission to hospitals with the philosophical shrug that only a people who survived the deprivations of the "London Blitz" period would.

#### Hostels

The British hostel, comparable to our skilled or custodial nursing home, is in such short supply that many patients must remain for extended periods in general and mental hospitals. This shortage was decried by MIND, the National Association for Mental Health, who claimed that "more than 3,000 long-stay patients in English and Welsh mental hospitals could leave immediately if homes or hostels were available." There are said to be 95,000 in-patients in British mental illness hospitals.

A MIND report stated that over a third of the

long-stay patients, some of whom had been in hospitals for more than ten years, were fit for immediate discharge and only the lack of accommodation and after-care facilities kept them in hospitals. It went on to say:

"Having prepared patients to live outside the hospital, it is extremely disheartening for both patients and staff that so many still remain. Rehabilitation programmes can only maintain momentum when all involved can see that there is a place to which patients can go at the end of the process."

#### Health Education and Preventive Medicine

Health education and preventive medicine seem to be low priority items in the National Health Service. In one health center we visited, health education materials were stored in a large closet and were presumably handed to some patients. The subjects covered were standard, i.e., nutrition, accident prevention, and so on, but there were no organized educational activities and individual instruction was minimal.

The multiple British cancer societies do some public education, but it is disorganized and fragmented. A leader of one such society admitted his envy of the American Cancer Society program and stated that the British were reluctant to use the word *cancer* in public messages until the American organization provided the example and the leadership some years ago.

Much of the health education falls to the district visitor who provides essential instruction to family members on her home visit rounds. This appears comparable to the traditional visiting nurse endeavors in the United States. One does not get bombarded in Great Britain with health messages attached to requests for charitable contributions, either by radio, television, or billboards, as is the case in our country.

A British observer of a Stanford University (California) Heart Disease Prevention Pro-



gram, which was described in *The Lancet*, gave a great deal of credit to the use of mass media and individual counseling by "lay preachers" (against smoking) in the United States study. The commentator went on to state with a touch of envy:

"The Stanford study has obvious implications for British health education: *our cardiovascular rates continue to rise while those in the U.S. decline*. But the six-figure budget doled out to the Health Education Council (H.E.C.) each year by the DHSS is unlikely to cover the expenses of a similar study. The Stanford Heart Disease Prevention Programme is looking for a further five million pounds from the U.S. Government to continue its work.

"The H.E.C., although helping to fund a few projects on the role of health education and cardiovascular disease, has still not devoted a public campaign to explain the dangers and has no immediate plans for one.

"British television, because of its national outlook, doesn't lend itself to community-based studies, and the Stanford results emphasize the importance of localized media. Public information films, shown free in Britain by independent television companies as well as the BBC, are rarely seen at peak viewing periods, if at all. But in the U.S., health education films on topics ranging from V.D. to fresh fruit are shown at all times of the day. Perhaps we should sit up and see what lessons are to be learnt."\*

*Preventive medicine* is now being raised as a goal in the United Kingdom because they have an essential tool, namely, the registration of each member of the whole population with a doctor. It appears there is a "plethora of reports, committees, and government papers imploring us (G.P.'s) to prevent disease," but the practitioners themselves are unimpressed with the "anguished cries of the politicians, the DHSS, and the scientists," believing the notion to be unrealistic and impracticable. The concept being considered seems to be a national computer-based system of *vulnerability classification* "in which those at very high risk indeed are invited frequently to the surgery or health centre for some kind of intervention—educational or presymptomatic diagnosis and perhaps treatment." The British GP is reluctant because the system "puts the doctor in the alarming position of knocking uninvited on his patient's door, rather than waiting to be asked to help. It is this role reversal rather than the uncertainties of the vulnerability business, which turns off so many doctors." In Great Britain, the GP appears to consider "preventive

medicine in general practice pie in the sky," but admits that "the GP is the only health professional who can make the diagnosis of vulnerability and also has the population upon which to make it."

### Relationship between Hospital Doctors and GP's

Reports during this visit to England displayed a grating friction between the GP and the hospital doctors. For example, junior hospital staff physicians have stated:

"To seek the admittance of a patient without actually visiting the patient that very day appears, in some hospital doctors' eyes, as being tantamount to grave dereliction of duty. Negligence of the highest order."

Casualty department doctors "stated emphatically they would refuse to see a patient unless it was seen by the GP first."

The GP, referring to the patient suspected of a "coronary," deplors this "red tape and protocol" indicating that the diagnosis of a coronary is made on the grounds of history rather than clinical findings." The GP's are angry at hospital doctors for "their ineptitude and reluctance to provide patients with National Insurance Certificates." They also complain that hospital doctors fail to notify them that their patients died or were discharged from the hospital, and that they refuse to write prescriptions for sufficient drugs to last until the next outpatient appointment. They also are miffed that the nursing service sometimes is notified of a patient discharge before the GP himself and that discharge notes or case note summaries are not received.

### Peer Review

There was little or no general evidence of an operational peer review system in force. A trifle of utilization review was described in the *British Medical Journal* recently. A group of Wiltshire GP's applied a system of peer review to their obstetric admissions and "found that by being critical they admitted fewer patients to the GP unit and referred more to consultant care." They studied high-risk patients (twins, breech presentations, elderly primipare and multiparae) and concluded that they deserve the care of specialists.

\*Pulse. July 16, 1977

## Physician Unions

In its July, 1977 meeting, The British Medical Association voted against affiliation with the TUC and a so-called "closed shop." This rejection of "unionism" by the national medical association contrasts with the attitude of members of COHSE "the powerful Health Service Union."

A Harley Street psychiatrist, who joined COHSE, explained:

"I used to be a BMA member. I resigned because I regard the BMA as a totally pusillanimous, castrated body for which I have no time. I think it has sold us down the line all the way. It's absolutely crazy what doctors have been prepared to put up with over the years, politically and financially."

An anomalous facet of unionism for doctors in the United Kingdom is that "COHSE is the driving force behind the elimination of pay beds from NHS hospitals, and their avowed aim is to halt all private practice in the United Kingdom." The same psychiatrist went on to philosophize about the nature of the British union:

"As far as the union maintaining differentials between doctors and cleaning ladies, I don't know whether they will do that particularly well or not. But I do know that they will do it better than if we were not in the union."

## Malpractice, Negligence, and Insurance

A tragic "cause celebre" was described in the London press during our visit and it has a familiar ring. It appears that a young British mother, who underwent minor surgery, suffered irreparable brain damage which left her hemiplegic, aphasic, and mentally obtunded when she was inadvertently given nitrous oxide instead of oxygen. The incident was investigated by a Regional Health Authority Committee who judged the incident an accident. It seems the nitrous oxide and oxygen supply hoses were accidentally disconnected and reversed by an unknown person. There were no color-coding, fail-safe connections or other protections. The injury was considered regrettable, but not compensable.

At the same time this case was reported, a Briton described the U.S. liability laws as "intolerable" in a letter to a British editor. He

stated: "Large numbers of underemployed lawyers (in the U.S.) are devising tortuous claims on a contingency fee basis and a proportion of them are succeeding." He compared the situation to "the hammer manufacturer who has been sued by the user who dropped it on his toes!"

Malpractice insurance in Great Britain has been available through "traditional defence societies," namely The Medical Defence Union and the Medical Protection Society. These are non-profit organizations which have kept premiums down to low fixed rates for many years. The BMA recently has explored the idea of having commercial insurance companies represent them, but there appears to be some debate on the subject. Defence societies have charged flat rates and kept administrative costs down while putting the "doctor's reputation before all considerations including that of cost."

The commercial carriers propose to vary premiums "according to the doctor's job." The charge for GP's and most physicians would be about 29 pounds a year and surgeons would pay 50 pounds to 125 pounds. The protection would cover claims up to 250,000 pounds and would include legal representation.

A recent DHSS circular warned both doctors and nurses, however, of the legal implications of their roles. The circular stated that the doctor is held responsible for actions delegated to nurses:

"Where delegation occurs, the doctor remains responsible for his patient and for the overall management of treatment, and the nurse is responsible for carrying out delegated tasks competently.

"In an action for damages, a nurse may be held legally liable if it can be shown either that she has failed to exercise the skills properly expected of her, or that she has undertaken tasks she was not competent to perform.

"The doctor may be held to be guilty of negligent delegation if it can be shown that he conferred authority on a nurse to perform a task which was either outside the scope of the duties she was normally expected to perform, or for which she had no special qualification."

Why is the malpractice scene so tranquil in Great Britain? According to a British barrister,

there are several factors at play. The National Health Service is organized so that criticism tends to be directed toward the Area Health Authority rather than individual doctors or nurses. The legal system itself is another reason. The concept of the solicitor as the first contact point and the barrister as the representative for litigation is crucial. Solicitors are paid "on a strict time/cost basis, while barristers act for a fixed fee, negotiated beforehand, and irrespective of the ultimate outcome." Most important, "Lawyers are forbidden to have any financial interest in the outcome of a case." Thus, "the English lawyer will decide whether a claim should be pursued purely on its merits." In England, the jury is not used in negligence litigation, which is heard by a High Court Judge. Awards in England for personal injuries are generally much less than \$100,000 with awards over that exceptional.

Probably the most important factor is attitude:

"Doctors have always been held in extremely high regard, and this, combined with a general disinclination on the part of the English to resort to the legal process, has meant that very few people consider suing a doctor."<sup>†</sup>

Dr. J. L. Taylor, secretary of the Medical Protection Society, recently assured British physicians that there is no rise in cases of negligence in England and they "need not feel alarmed by the American medico-legal boom." He attributed the increase in damages in Britain "to inflation and the higher value which society places on disability." Dr. Taylor admitted that "the patient has a perfect right to make a claim against his doctor. But, he must be aware that in consulting his doctor and availing himself of the benefits of modern medicine, he is taking a certain risk."

### Summary

The British National Health Service is a troubled, expensive, crisis-care oriented program which was originally based on an outrageously naive concept—that the program would obtain good health for all participants, maintain that state of physical and mental soundness and thus contain and reduce costs.

<sup>†</sup>Martin, AJ: The malpractice situation in Britain and the USA. *Medical Times* 105: 45-49, August, 1977.

Instead, it has become top-heavy with layers of bureaucratic controls and personnel, short of funds, understaffed with workers, and troubled by endless debates between the health professionals, the Houses of Parliament, the political parties, and the health economists.

Despite the seemingly unlimited stoicism and tolerance of the British populace, cracks have shown through. The NHS appears incapable of solving the major cost—hospital bed utilization—despite their total dominance of the health care system. The nearly 600,000 on the national waiting list for hospital admissions grows longer each year while tempers grow shorter.

Doctors in England are second-rate citizens with no greater privileges than coal miners and cleaning ladies, despite their great responsibilities. Individual initiative and professional competence are rewarded in theory but not in practice.

Concepts such as peer review and utilization review have not penetrated the NHS, despite the massive government system of controls. Unsafe, archaic physical hospital facilities are still used. There is a shortage of nursing home beds and rehabilitation facilities. Health education, preventive medicine, and disease detection are considered low on the priority list.

While some of the medical and surgical care at the highest level is among the best in the world, the bulwark of British medicine, the general practitioner, mainly provides crisis care, prescriptions, and national insurance certificates. The pay scale for doctors is a disgrace, and the standard of living is moving down with pay increases restricted to 2.5 percent while inflation rates are 15 to 17 percent per year.

The problems of the British National Health Service are apparently not limited to health alone. In a discussion of the evident failure of social democracy in the United Kingdom, a *London Times* commentator made these statements:

1. "It has increasingly seemed to many people that socialism has now achieved so tight a grip on the life and government of the nation at the expense of individual



freedom that if it is not halted, and to some extent reversed by a genuine alternative kind of politics, it will march on to a total dominance that cannot be reconciled with personal freedom.

2. "There has increasingly seemed to be evidence that social democracy simply does not work because it delivers substandard goods to its consumers. It would need a very stalwart defender of the socialized system who could say,

for instance, that either the health or the education services inspire much confidence in their users—who are the overwhelming majority of the people."

A. Krosnick, M.D.

Parts I and II of the commentary on the British National Health Service appeared in the September (74:785-787) and October (74:887-890) issues of *The Journal*.

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**May 6-9, 1978**

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# NEW JERSEY DOCTORS' NOTEBOOK

## Trustees' Minutes

September 18, 1977

A regular meeting of the Board of Trustees was held on Sunday, September 18, 1977, at the Executive Offices, Trenton. Detailed minutes are on file with the secretary of your county medical society. A summary of significant actions follows:

*Academy of Medicine* . . . Authorized publication of a letter by Dr. Begen in *The Journal* urging members of MSNJ to join the Academy (only 16 percent of the Society are members). A membership application form will accompany the letter.

*AMA Delegation* . . . Directed that a vigorous campaign for Society members to join the AMA be instituted. This was occasioned by the current AMA membership figures (August 1977) which indicate that MSNJ needs an additional 43 AMA members to maintain current delegation strength of 7, or an additional 1,043 to return to an 8-member delegation.

*Burn Foundation of Greater Delaware Valley* . . . Endorsed an in-depth study of hospitalized burn patients by the Burn Foundation of Greater Delaware Valley, and the Foundation's application to the Federal government for grant funds. The area under study would include the eleven central and southern New Jersey counties as well as the five-county Philadelphia area.

*The Impaired Physician* . . . Approved the final report of the Ad Hoc Committee on the Impaired Physician after amending the proposed Impaired Physician Program to include all physicians in the State, not only MSNJ members.

. . . Voted to extend the scope of the Impaired Physician Committee, retaining the present chairman and members, making it a Special

Committee empowered to cooperate with the New Jersey Department of Health and to implement and report directly to the Board, and to recruit as consultants to the committee those of CMDNJ's administrative staff suggested by Dr. Bergen.

*Inaugural Reception and Dinner* . . . Reviewed the report of the Standing Committee on Annual Meeting and its study of attendance and cost figures for these functions at the Annual Meeting, and approved the following recommendations as amended by the Board:

(a) That both the Inaugural Reception and Dinner be continued as social functions of the Annual Meeting.

(b) That sponsorship of both the Inaugural Reception and the Inaugural Dinner be combined: MSNJ and the component society are equal *planning* sponsors. (Italics indicate amendment by Board of Trustees.)

(c) That the past cooperative efforts of MSNJ and the sponsoring component society be continued, but that the reception planning be delegated to MSNJ and the dinner program and planning be the responsibility of the component society with the advice, consent, and coordination of MSNJ.

(d) That the Committee on Annual Meeting prepare and approve the guest list and that MSNJ assume responsibility for the purchase of guest tickets for all guests at the Inaugural Dinner.

(e) That the Board of Trustees adopt a policy that the Committee on Annual Meeting provide an estimated budget and a post-meeting accounting of the different functions which are components of the Annual Meeting.

*MSNJ Department of Liability Control* . . . Considered the report of Dr. James E. George, director of MSNJ's Department of Liability Control, detailing his visit to the Halifax Hospital Medical Center in Daytona Beach, Florida, to determine the possible applicability of a Medical Incident Committee to MSNJ. Dr. George indicated two defects in the MIC which are inherent to MSNJ's Medical Review and Advisory Committee hearings—absence of the defendant physician, and presence of the defense attorney whose emphasis on legal, social, and non-medical factors precluded adequate discussion of the medical aspects of the case.



... Referred the following recommendation to the Standing Committee on Medical Defense and Insurance for implementation:

That steps should be taken by MSNJ to encourage alternative methods of fact development and case work-up for purposes of defense or settlement. At the outset this should include more interaction with the defendant and less with the defense attorney.

... Referred the following recommendation to the Joint Executive Committees of MSNJ and NJHA for development:

That physician/hospital MIC pilot projects be initiated by MSNJ and NJHA in a few selected hospitals in the northern, middle, and southern parts of New Jersey. The Captive insurance companies of both MSNJ and NJHA should work cooperatively to monitor the effectiveness of these MIC's.

... Recognized that rapid handling of claims keeps settlement costs down and recommended:

That MSNJ encourage NJSMU's Claims Department to be staffed with sufficient numbers of skilled personnel to keep up with increasing claims volume. It is imperative that claims be dealt with on a current basis to preserve all options associated with settlement or defense.

*N.B.* Dr. Todd stated that regional claim offices are being planned to expedite prompt handling.

#### *Practice-Related Education Program (PREP)*

... Approved the report of the Standing Committee on Medical Education on the Practice-Related Education Program of the College of Physicians and its possible use as a CME tool by New Jersey physicians, and approved the following recommendations:

(1) That the Board of Trustees of MSNJ officially endorse the PREP proposal as developed and presented by the College of Physicians.

(2) That the agreement between the College of Physicians of Philadelphia, the Academy of Medicine of New Jersey, and MSNJ be approved, with MSNJ being responsible for the financial expense of distributing the program to the membership.

*American Hospital Association House of Delegates* ... Received as informative a written report from Dr. John S. Madara on his recent attendance at the American Hospital Association House of Delegates in Atlanta, Georgia—copy is on file in the Executive Offices.

#### *Revision of Rider J Laboratory Fee Schedule*

... Considered the revised recommendation from the Council on Medical Services on medical necessity (Board had ruled that the original recommendation was not within the purview of the Society to approve or disapprove fee schedules relating to MSP coverages):

That the Board of Trustees accept the revisions of the Blue Shield of New Jersey laboratory fee schedule and the concept behind these revisions:

(1) That of promoting quality of care and removing from the procedure code items which have become obsolete, as outlined in Blue Shield's letter of March 11, 1977.

(2) That it includes a recommendation that payment is not categorically denied; but that after appropriate and timely notification of the profession, payment be made only upon submission of a report satisfactorily establishing medical necessity. (Doctor Cuniff assured the Council that this latter concept was the intended policy of Blue Shield of New Jersey and would so be stated in the final draft.)

... Referred the revised recommendation to the Council on Medical Services for reconsideration, and requested a broad definition of medical necessity. It was suggested that Dr. Bernstein be invited to the next meeting to discuss the Board's position on the subject. It was further suggested that representatives of third party payers also be invited to attend.

#### *Unlicensed Physicians in State Hospitals*

... Voted to support the State Board of Medical Examiners and the NJHA relative to discontinuing the use of unlicensed physicians in state hospitals.

*CME Requirements* ... Recommended that the names of physicians delinquent in completing CME requirements be given to the appropriate county for action. Members of the Board also will be given a list of delinquent doctors in their respective districts.

*Nuclear Medicine Technology* ... Received as informative MSNJ's letter to the Bureau of Radiation Protection, Department of Environmental Protection, expressing concern about the creation of a field of licensure with legislative authorization via adoption of regulations which exceed the existing statutory grant of authority. This followed Dr. Witomski's testi-

mony at a hearing on July 13 presented in behalf of the N.J. Radiological Society and MSNJ opposing proposed regulations on nuclear medicine technology.

*Primary Health Care Nurse Clinician Program . . .* Voted against endorsing the proposed Program on Primary Health Care Nurse Clinician submitted by Seton Hall University College of Nursing Graduate Program submitted for MSNJ review.

*Study of Immunization Liability Difficulties . . .* Voted to support a study by the American Arbitration Association of immunization liability difficulties, and to contribute \$2500 toward the expenses involved in developing a comprehensive system to protect all participants in future vaccination and immunization programs of all types.

*Policy Position on Prepaid Health Care . . .* Voted to adopt the following resolution submitted by the New Jersey Foundation for Health Care Evaluation:

Whereas, activity in the prepaid concept of health care delivery is already present in ten areas of New Jersey; and

Whereas, additional areas in our State are becoming interested in organizing prepaid plans; and

Whereas, the additional stimuli of government, industry, and labor will tend to accelerate the promotion of the concept; and

Whereas, the New Jersey Foundation for Health Care

Evaluation believes that the Individual Practice Association is the most desirable form of prepaid care for patients and physicians; now therefore be it

RESOLVED, that the New Jersey Foundation for Health Care Evaluation, in conjunction with the Medical Society of New Jersey, conduct an informational meeting on the concept of prepaid medical care in New Jersey; and be it further

RESOLVED, that officers and delegates of the component medical societies, as well as representatives of the specialty societies, be urged to participate in such a meeting, and in the study of desirable options of methods of delivery of care under the prepaid method.

*Reports on Future Board of Trustees' Agenda . . .* Agreed to Dr. Todd's request that the Board's monthly agenda include reports from Dr. Stanley S. Bergen, President, College of Medicine and Dentistry of New Jersey; Mr. Jack Owen, President, New Jersey Hospital Association; and from the Medical Society of New Jersey Student Association—these to follow the Executive Director's report.

*Use of Amphetamines . . .* Considered information received from the New Jersey State Board of Medical Examiners concerning the use of amphetamines and the group of sympathomimetic amines in cases of narcolepsy, minimal brain dysfunction, and obesity.

. . . Directed that the State Board of Medical Examiners be apprised of MSNJ's concern that the information reviewed be disseminated to all practicing physicians, hospitals, and facilities in the State, and of MSNJ's opinion that there should be no retroactive accountability.

## 212th Annual Meeting May 6-9

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**See housing application — p. 993, this issue**

# The Reduction of Hospital Malnutrition\*

That malnutrition exists in hospitals has been documented.<sup>1</sup> The gravity of this problem also has been noted recently in an editorial in the July 1976 issue of *The Journal* of the Medical Society of New Jersey (73:567-568).<sup>2</sup>

Stimulated by the earlier reports of hospital malnutrition, an Inter-Agency Steering Committee (IASC)† was initiated by the Medical Society of New Jersey (MSNJ) to determine what dietary practices were prevalent in the 50 teaching hospitals in New Jersey. In that connection, a survey was designed and executed during 1975. A summary report was published in 1976.<sup>3</sup>

Briefly, the IASC survey found a general lack of communication between administrators, dietitians, physicians, and nurses. Fifteen of the 50 teaching hospitals surveyed had no stated objectives with regard to education of health professionals working and/or training on the premises; 16 did not have a dietary committee. Patients were routinely weighed on admission in only 28 hospitals. In only three hospitals were there clear responsibilities defined for the dietitians in the nutrition education of physicians-in-training.

The purpose of this communication is to report on the major recommendations<sup>4</sup> that have

emerged to help repair the defects in nutrition services and education that were reported in that survey.

**Organization of Dietary Services**—The Department of Dietetics in a hospital, since it has direct responsibilities for patient care, should be aligned with those other disciplines which have similar responsibilities. As a first step in improving nutritional practices, a Department of Dietetics must establish objectives and long and short-term goals. It also must be able to evaluate its services and implement the policies and procedures it has established.

The chief responsibility of a dietary department is to insure the provisions of adequate nutritional care for all patients.\*\* In order to do this effectively, it must develop the means for individual assessments of nutritional status as well as the ability to conduct continued monitoring. Finally, the department needs to develop coordinating formal and informal in-service education with patients, staff, students, and the public.

There are a number of organizational models in use that can accomplish these purposes within the constraints of modern hospital finances. For example, a hospital might sign a contract with a food service whose manager could suggest innovations in hospital food management. More efficient management could in turn provide resources for improved nutrition services and education for patients, professionals and students from all disciplines.

**Maintenance of Professional Competence (Education)**—For a hospital to assure total health care of its patients, as noted above, it must routinely assess and monitor the nutritional status of the patients. A staff that is skilled in these activities is crucial in establishing the relevance of good nutrition to total health care. Since this is not now being done, present staff as well as students will need to acquire these skills. It is necessary, therefore, to identify and develop clinical settings that make such experiences possible. All the staff members in a clinical setting will need to be oriented to the objectives of the educational experience, so that they can contribute to the preparation of the content as well as serve as models of good

\*A report on the recommendations prepared by the Inter-Agency Steering Committee for the Medical Society of New Jersey by Robyn Chernish, M.S., R.D. and Howard N. Jacobson, M.D., Department of Community Medicine, CMDNJ-Rutgers Medical School. Dr. Jacobson is Chairman, Committee on Nutrition, MSNJ and Ms. Chernish is Nutrition Care Coordinator, Perth Amboy General Hospital. This report was supported by a grant from the Foundation of the College of Medicine and Dentistry of New Jersey.

†Jane Bryson, R.D., N.J. State Dept. of Health; Harriet Kahn, R.D., N.J. Dietetic Association; Norval Kemp, M.D., Elizabeth Munves, Ph.D., Richard Podell, M.D., the Medical Society of New Jersey; Evelyn McLaughlin, R.N., N.J. State Nurses' Association; Lorraine Weng Shafer, R.D., Claire Stone, R.D., N.J. Nutrition Council; Louis C. Haenal, D.O., N.J. Osteopathic Association; Howard N. Jacobson, M.D., Chairman, the Medical Society of New Jersey.

\*\*Complete details can be found in the *Journal of the American Dietetic Association* 64:661, June 1974.



practices. For these situations to be realized, there must be assurance that there is adequate staff to provide both teaching and supervision.

Examples of clinical settings that are available in most hospitals and that are suitable for learning experiences in applied nutrition are presented in Table I.

Table I

*Clinical Settings Suitable for Nutrition Education*

a. *Orientation*—A presentation by the food services and clinical nutrition services should be offered to all new students and staff to acquaint them with policies, procedures, and practices.

b. *Conferences and Grand Rounds*—Nutritional management should be part of all regularly scheduled conferences in all areas of patient services.

c. *Patient Education and Counseling*—Students should have the opportunity of working with a dietitian in patient assessment and in care planning and management.

d. *Work Rounds and Staff Conferences*—Whenever possible, the team approach should be practiced.

e. *Therapeutic Luncheons*—Typical patient meals can be served to teach participants about the foods available on modified diets and the management, adherence, and documentation problems involved.

f. *Community Health Education*—Emphasis should be placed on prevention and follow-up.

**Quality Control**—There is an acknowledged need to monitor and to improve hospital dietary services in daily practice. It is in this connection that a Nutrition Advisory Committee is essential. Such a group can oversee the quality of nutrition and food services. It can foresee the future needs and changing trends in the field. It can also make recommendations that lead to improved policy decision within the institution. Since nutritional care touches nearly all segments of health care, the membership of the Committee should be made up of a mixture of health professionals.

The missions of a Hospital Nutrition Advisory Committee are to function as an investigating and reporting group concerned with any nutritionally related practice or policy in the hospital and to provide recommendations and advice to administration on its findings. Its responsibilities would be, therefore, to investigate any practice or policy that affects the delivery of optimal nutritional care, and to

report their findings with documentation. It would make recommendations on nutritional practices and policies, and it would advise the hospitals on decisions made concerning dietary service practices and policies.

The 1975 survey identified a number of topic areas that are of direct concern for this Advisory Committee, some of which are listed in Table II.

Table II

*Proper Concerns of a Hospital Nutrition Advisory Committee*

a. *Food Service*: availability of special food products, requisitioning procedures, special billing procedures.

b. *Nutritional Care*: tools used, counseling services available, health care team participation, dietary prescriptions, diet manual.

c. *Utilization and Documentation*: charting procedures for the nutritional care plan, questions of malpractice due to dietary services, justification of laboratory tests in nutritional assessment.

d. *Reimbursement Policies*: health insurance policies, state inspection regulations affecting licensure and accreditation.

e. *Education*: evaluation of programs available for patients, students, staff, and the public.

f. *Research*: recommendation of programs and policies which support nutrition research and the prompt use of the findings.

g. *Surveys*: serve as hospital advocate on the needs, desires, acceptance and effectiveness of hospital nutrition services.

**Conclusions**—These recommendations point up the actions needed to improve the dietary services for our patients and for more effective means of assuring that the quality of services is maintained.

*References*

<sup>1</sup> Butterworth C: Skeleton in the hospital closet. *Nutrition Today* 2:4, 1974.

<sup>2</sup> Editorial: *The Journal of the Medical Society of New Jersey* 73:567-568, July 1976.

<sup>3</sup> Jacobson HN: Dietary practices, services, and trends in the teaching hospitals in New Jersey. *Nutrition Today* 10:14, 1975.

<sup>4</sup> Recommendations Prepared for the Inter-Agency Steering Committee† for submission to the Medical Society of New Jersey, July 28, 1976.

†Note—Complete set of recommendations can be obtained from MSNJ, P.O. Box 904, Trenton, New Jersey 08605.

## CMDNJ Notes

Stanley S. Bergen, Jr., M.D.  
President, CMDNJ

(This month's column is an abstract of a paper, entitled "A Medical School and its Community: The Newark Experience," that I delivered at the Assessment of Newark 1967-77 Conference on October 1. Co-sponsors of the Conference with CMDNJ were Essex County College, New Jersey Institute of Technology and Rutgers University—College of Law, School of Criminal Justice, College of Arts and Sciences at Newark, Graduate School of Business.)

Newark's evolution over the last ten years represents, in microcosm, the social turmoil that has faced our nation during this period. The series of issues that confronted the College and its move to Newark in the mid-1960s were spawned by a growing desire for community involvement and demands for access to higher education and improved health-care services.

A public institution such as CMDNJ must serve multiple communities. In all probability there has been no more sensitive area of confrontation and discussion than that represented by the encroachment into a deprived area of a medical/dental complex providing education opportunities and access to extensive economic gains for a few while offering potential improvement in health-care services and equal access to quality health care for many.

In 1964, the State assumed operating responsibilities for the Seton Hall College of Medicine and Dentistry. Although it was agreed that the dental school would remain temporarily in Jersey City, there followed a long battle over the medical school's location: a bucolic setting in Madison vs. a site in Newark's Central Ward.

After political maneuvering, the trustees and Governor Hughes decided the College would be moved to Newark and that the old Newark City Hospital would serve as a teaching facility. These decisions were based on the potential economic impact of new construction and employment for Newark. Nonetheless, there was a general feeling of anger in the city against public institutions, particularly those representing authority which previously had denied the community access to the decision-making

process. The CMDNJ faculty failed to understand the ensuing conflict and resented being caught in the middle.

Following the riots of 1967, a significant unresolved issue was the nature and amount of community input to determine the eventual configuration of the College campus and the services to be provided to the community. Seven months of difficult negotiations on establishment of the school complex resulted in the Newark Agreements. The document takes under consideration the expectations of the community for employment, health services and educational opportunities. Unfortunately, the College's faculty and administration played little part in these negotiations and therefore had many of the provisions imposed upon them. The medical school suddenly found itself the culprit, rather than a struggling institution trying to find a permanent location while offering opportunity for vastly improved health services.

The Newark Agreements dealt with acreage, health services, employment, training, a teaching hospital, community health services, and the need for special minority student recruitment and enrollment programs. It also dealt with the affirmative action requirements for construction, upgrading of residents for employment in health-care and relocation for those with on-site dwellings. The Agreements paved the way for the largest single federal grant ever awarded a state or educational institution, but this award brought with it strictly-enforced regulations concerning minority employment and construction-worker training programs. These agreements were to be constant points of friction between the institution and the community.

In late 1970, community dissatisfaction with Martland Medical Center resulted in confrontation and the hospital was occupied by community groups who attempted to assume the direction of the institution. A Board of Concerned Citizens then was organized by the College. Representing an interface among employees, community agencies, consumers, administration and the faculty of the College, the Board has served multiple roles: conscience

for the institution, provocateur of response and accountability, and representative of the institutional position. Although the Board has been accused of intrusion into areas traditionally sacred to academicians, it generally has been astute in identifying and avoiding its areas of lack of expertise.

A major issue developed in 1971 when Mayor Gibson questioned the concept of the two-hospital system. This led to the redesign of the new referral hospital into a comprehensive health-care facility that both would serve the needs of the medically indigent and act as a referral facility for northern New Jersey.

During the past six years, the College has been confronted with the issue of minority recruitment and retention for admission to health-profession schools. This issue has been particularly critical in Newark because of the population distribution and the recognized need for the entry of minority individuals into medical and dental careers. While the issue of reverse discrimination remains with us, there has been a noticeable improvement in relationships among the faculty, the students and the community over this issue as the academic performance of minority students has improved.

Most of these events have led to productive dialogue and resolution of the problems. Most challenges to the autonomy of the institution have been adjusted, and I believe that the institution has gained an inner strength in the process. At present, we continue to seek new methods of assuring interface with our community and a proper balance between community representatives and academic freedom.

## Report from the Foundation

Daniel J. O'Regan, M.D., Medical Director

The stimulus provided by the existence of ten prepaid health care organizations is inducing more reaction on the part of our colleagues. The initial responses were of the reflex variety: speedy withdrawal of attention, with the hope that the noxious intruder would go away. With

the passage of time, more rational processes have taken over. Increase in interest and activity is present in Middlesex, Union, Passaic, Hunterdon, and Cumberland counties. Several county medical societies have voted to pursue feasibility funds from HEW under the cycle announced last summer.

NJFHCE, with the assistance of funds provided by MSNJ, has been studying these developments, as you know. As a result of the fact that our people were invited to three successive evening meetings at three component society meetings—on IPA—our IPA Study Group felt that there should be a full-scale meeting on this topic. Following a proposal from NJFHCE's Board of Trustees to the Board of Trustees of the Medical Society of New Jersey, it was agreed that a meeting on Health Maintenance Organizations (HMOs) and Individual Practice Associations (IPAs) will be held, under joint MSNJ and NJFHCE sponsorship, on Wednesday, December 7, 1977, 10 a.m. to 4 p.m., at the Holiday Inn on Route U.S. 1, in North Brunswick. There will be full coverage by speakers of national prominence, as well as experienced experts from our own New Jersey colleagues. Every component medical society and every specialty society should be represented at this seminar, since it must be obvious to all physicians that prepaid health care, in one form or another, does exist and will continue to operate in New Jersey. NJFHCE, as has been stated in this space many times, believes that Individual Practice Associations (IPAs) represent the most desirable form of prepaid health care, since this concept is closest to the traditional form of medical care delivery: it offers freedom of choice for physicians and patients and permits the doctor to continue practice in his own office. Like other prepaid plans, it is not without risk. It is not as simple as changing your letterhead and conducting business as usual. It may not be attractive to you in your area, with your patient group. It was not attractive to *any* of our colleagues three or four years ago. Prepaid health care must have caught your attention. To be better informed about its possibilities, and the options available, plan to attend the December 7 meeting.



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Robert H. Lombert,  
Director of Finance and Administrative Services

## Therapeutic Drug Information Center\*

### 1. Please provide information of Gerovital H-3

Gerovital H-3 (Rom-Amer Pharmaceuticals) is a solution of procaine hydrochloride stabilized with benzoic acid and potassium metabisulfite for systemic administration. A number of claims have been made for the systemic use of procaine in reversing or delaying the aging process and altering favorably the common disorders of later life.<sup>1-4</sup> The preparation is under investigation in the United States for possible antidepressant effects.<sup>5</sup>

Zwerling, *et al.*<sup>6</sup> assessed the effects of Gerovital H-3 on the psychologic and physiologic functioning on 32 geriatric patients in a placebo-controlled, double-blind study. The patients were divided into two groups—one consisting of 19 patients (group A) and the other consisting of 13 patients (group B). Nine patients of group A received 100 mg of the drug intramuscularly twice a week for six weeks. The other 10 received saline and served as controls. In group B, six patients received 200 mg of Gerovital H-3 intramuscularly twice a week for 12 weeks. The remaining seven patients received saline in a similar fashion. Assessment of the patients was done before treatment, at the end of six weeks, and at twelve weeks. The overall results indicated that Gerovital H-3 had no ameliorative effect on either psychologic or physiologic functioning.

In an open trial, antidepressive activity of Gerovital H-3 was investigated in ten senile, arteriosclerotic patients. The drug (100 to 200 mg) was administered intramuscularly twice a week for three weeks. The results indicated a possible transient beneficial effect on depressive symptomatology which the authors ascribed to an MAO inhibitory effect of procaine.<sup>7</sup>

Ostfeld, *et al.*<sup>8</sup> reviewed and evaluated about 285 articles and books, describing treatment with systemic procaine of approximately 100,000 patients with various disorders. The authors found no convincing reports of the effectiveness of procaine in the treatment of the diseases in old people.

\*The Schwartz Inter-National Pharmaceutic and Therapeutic Drug Information Center of the Brooklyn College of Pharmacy, Long Island University, compiles the information contained in this column each month. The Center serves as a source of intelligence on therapeutic and pharmaceutical information not readily available to physicians, at no charge to them, and provides this information with minimal time involvement. It is staffed by trained pharmacists; Jack M. Rosenberg, Pharm. D., Associate Professor and Chairman, Division of Clinical Pharmacy, Brooklyn College of Pharmacy, is Director and Walter Modell, M.D., Emeritus Professor of Pharmacology at Cornell University Medical College, is pharmacologist consultant. The service is available Monday through Friday from 9 a.m. to 4:30 p.m.—telephone (212) 622-8989 or 303-2735. The following are questions and answers handled by the Center recently.

This month's column was prepared by J. M. Rosenberg, M.S., Pharm. D., M. K. Raina, M. Pharm., Ph.D., P. Sangkachand, B.S., Doris Lau, B.S., Brooklyn College of Pharmacy, LIU.

However, procaine hydrochloride seemed to possess antidepressant activity.

In conclusion, procaine may have a possible antidepressant activity. This can be confirmed only after the results of further well-controlled trials are available.

## References

<sup>1</sup>Fee SR and Clark ANC: Trial of procaine in aged. *Brit Med J* 2:1680-1682 (Dec 23) 1961.

<sup>2</sup>Berryman JAW, Forbes HAW, and Simpson-White R: Trial of procaine in old age and chronic degenerative disorders. *Brit Med J* 2:1683-1684 (Dec 23) 1961.

<sup>3</sup>Hirsh J: Clinical trial of procaine hydrochloride. *Brit Med J* 2:1684-1685 (Dec 23) 1961.

<sup>4</sup>Isaacs B: Trials of procaine in aged patients. *Brit Med J* 1:188-189 (Jan 20) 1962.

<sup>5</sup>Kent S: A look at Gerovital—The "youth" drug. *Geriatr* 31:95-96, 101-102 (Dec) 1976.

<sup>6</sup>Zwerling I, et al: Effects of a procaine preparation (Gerovital H-3) in hospitalized geriatrics patients: A double-blind study. *J Am Geriatric Soc* 23:355-9 (Aug) 1975.

<sup>7</sup>Sahalis G, et al: A trial of Gerovital H-3 in depression during senility. *Curr Ther Res* 16:59-63 (Jan) 1974.

<sup>8</sup>Ostfeld A, et al: The systemic use of procaine in the treatment of the elderly: A review. *Am Geriatr Soc* 25:1-19 (Jan) 1977.

## 2. Please provide information regarding the use of bromocriptine in parkinsonism.

Bromocriptine (2-brom- $\alpha$ (ergokryptine, parlodel) is a semi-synthetic ergot alkaloid, under investigation in the U.S.A. by Sandoz. Pharmacologically it is a dopamine agonist and has been used in the treatment of various disorders including galactorrhea, infertility, acromegaly, and parkinsonism. Use of bromocriptine in parkinsonism is attracting attention because of its direct action on the dopamine receptors; and unlike levodopa (Bendopa<sup>®</sup>; Larodopa<sup>®</sup>; Dopar<sup>®</sup>) does not require the presence of the enzyme amino acid decarboxylase for effective action. The drug also has been reported to be effective in certain patients who fail to respond to levodopa.

Calne et al.<sup>1,2</sup>, in 1974, reported bromocriptine had significant antiparkinsonian effects in man. Teychenne, et al.<sup>3</sup> conducted a double-blind, within-patient, comparison study on 28 patients with idiopathic parkinsonism who were treated with levodopa or levodopa-carbidopa combination (Sinemet<sup>®</sup>). The dose of bromocriptine was gradually introduced with a reduction in levodopa dosage. At a mean dose of 46.9 mg daily, bromocriptine showed a statistically significant therapeutic response. Of the 28 patients, 14 were able to stop levodopa and/or levodopa with carbidopa. In five patients the dose of levodopa was reduced by 54 percent, whereas eight patients could not tolerate bromocriptine. One patient was dropped from the study because of noncompliance. Adverse reactions including dyskinesias, mental effects, and nausea were similar to those encountered with levodopa and were reversible.

Lieberman, et al.<sup>4</sup> reported a six-month trial with bromocriptine in 14 patients having parkinsonism who were on levodopa therapy for about five years. These patients were no longer responding to levodopa with or without carbidopa. Bromocriptine was administered at an initial dose of 5 mg a day. The dose was increased weekly with simultaneous lowering of levodopa or levodopa-carbidopa dosage.

With a mean dose of 57 mg of bromocriptine per day and lowering of levodopa dose by 31 percent, ten out of 14 patients showed a significant improvement with reduction in rigidity, tremor, and gait disturbances. In seven patients levodopa or levodopa/carbidopa was completely withdrawn. Adverse reactions observed were, in general, similar to those seen with levodopa. There was a significant increase in adverse mental changes and orthostatic hypotension with bromocriptine compared with levodopa or the combination of levodopa/carbidopa.

Kartzinell, et al.<sup>5</sup> reported a double-blind, crossover study lasting six months on 20 patients with idiopathic parkinsonism who were already on optimum doses of levodopa with or without carbidopa. The study was divided into three phases. In the first phase or "baseline" period, the patients were given placebo and the optimum dose of levodopa or levodopa/carbidopa was established and continued. In the second phase, a low dose of bromocriptine (2.5 mg twice daily) was substituted for placebo with a gradual decrease in levodopa or levodopa/carbidopa dosage. In the third phase, the patients received the highest dose of bromocriptine that they could tolerate with corresponding reduction and/or withdrawal of levodopa with or without carbidopa. At a mean daily dose of 79 mg of bromocriptine, there was a significant (74 percent) reduction in the dose of levodopa or levodopa/carbidopa, and these drugs were entirely withdrawn from six patients. "Total disability score" showed a statistically significant improvement during both the second and third phases, when patients received low and high doses of bromocriptine respectively. There also was improvement in tremor, gait, posture, and writing of the patients. Adverse reactions were similar to those observed with levodopa with or without carbidopa. In this study bromocriptine was found to be superior to levodopa/carbidopa or levodopa in the treatment of idiopathic parkinsonism.

In conclusion, bromocriptine appears to be a promising drug for the treatment of parkinsonism, especially for those patients who became refractory to levodopa or levodopa/carbidopa treatment.

## References

<sup>1</sup>Calne DB, et al: Bromocriptine in parkinsonism. *Br Med J* 4:442 (Nov 23) 1974.

<sup>2</sup>Calne DB, et al: Treatment of parkinsonism with bromocriptine. *Lancet* 2:1355 (Dec 7) 1974.

<sup>3</sup>Teychenne PF, et al: Idiopathic parkinsonism treated with bromocriptine. *Lancet* 2:473 (Sept 13) 1975.

<sup>4</sup>Lieberman A, et al: Treatment of Parkinson's disease with bromocriptine. *N Eng J Med* 295:1400 (Dec) 1976.

<sup>5</sup>Kartzinell R, et al: Bromocriptine and levodopa (with or without carbidopa) in parkinsonism. *Lancet* 2:272 (Aug 7) 1976.



### 3. Is it feasible to administer diazepam on a once-daily basis for maintenance therapy?

Diazepam is rapidly and completely absorbed after oral administration, reaching peak blood concentration within 30 minutes to three hours after a single oral dose. The drug is metabolized slowly, with a half-life between 20 to 40 hours in most subjects, but as long as 50 hours in others. The major metabolites of diazepam, desmethyldiazepam and oxazepam, have psychopharmacological activity. During chronic oral medication, diazepam and its metabolites accumulate in the blood and a steady state is reached after four to ten days.<sup>1-5</sup>

The official literature of diazepam recommends the dosing frequency of diazepam as 2 to 4 times a day.<sup>6</sup> However, pharmacokinetic characteristics indicate that once a steady state concentration in the blood is reached, between four to ten days, once-a-day administration may be sufficient to maintain the effective plasma concentration.

Van der Kleijer,<sup>7</sup> studied the pharmacokinetics of diazepam in ten psychiatric patients. Each patient received orally 10 mg of diazepam three times a day for two weeks. The author observed that half-life of both diazepam and its metabolites was longer than common dosage intervals used in practice.

*The Medical Letter* consultants, while reviewing the choice of benzodiazepines in anxiety and/or insomnia, concluded that multiple dosing of diazepam is unnecessary once the steady state is reached, and that the drug can then be given once or twice daily.<sup>8</sup>

In conclusion, it appears that diazepam may be administered once or twice a day after the steady state concentration is reached which is usually after four to ten days of therapy.

#### References

<sup>1</sup>de Silva JAF, *et al*: Blood level distribution patterns of diazepam and its major metabolite in man. *J Pharm Sci* 55:692 (July) 1966.

<sup>2</sup>Hillestad L, *et al*: Diazepam metabolism in normal man. *Clin Pharm Ther* 16:479 (Sept) 1974.

<sup>3</sup>Gamble JAS, *et al*: Plasma levels of diazepam. *Brit J Anaesth* 45:1085 (Oct) 1973.

<sup>4</sup>Kanto J: Plasma levels of diazepam after oral and intramuscular administration. *Brit J Anaesth* 46:317 (Nov) 1974.

<sup>5</sup>Anon: Drug actions, interactions, and reactions. *Drug Intell Clin Pharm* 8:615 (Oct) 1974.

<sup>6</sup>Anon: *Physicians' Desk Reference*, 31st edition. Oradell, N.J., Medical Economics Co., 1977, p. 1339.

<sup>7</sup>van der Kleijer E: Pharmacokinetics of distribution and metabolism of ataractic drugs and an evaluation of anti-anxiety activity. *NY Acad Sci* 179:115-25 (July 6) 1971.

<sup>8</sup>Anon: Choice of a benzodiazepine for treatment of anxiety or insomnia. *The Medical Letter* 19:12:49 (June 17) 1977.

## Physicians Seeking Location in New Jersey

*The following physicians have written to the Executive Office of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.*

**ANESTHESIOLOGY**—Margarita Bravo, M.D., 51-15 Van Kleeck Street, Apt. 2-G, Elmhurst, New York 11373. Univ. of Philippines 1969. Board eligible. Group or partnership. Available.

Wagdy Farid Aziz, M.D., 7 Hegeman Ave., Apt. 11-G, Brooklyn, New York 11212. Ein Shams Medical College (Egypt) 1964. Board eligible. Solo, partnership, single-specialty group. Available December 1977.

**FAMILY PRACTICE**—Jon K. Sternburg, M.D., 777 South Mills Street, Madison, Wisconsin, 53715. George Washington University 1974. Board eligible. Group (single specialty). Available September 1978.

**GENERAL PRACTICE**—John D. Gawlik, M.D., 464 Chapman Street, Irvington, N.J. 07111. St. Louis University 1969. Group or partnership. Available.

**INTERNAL MEDICINE**—Ira Spiler, M.D., 27 Sutherland Road, Brighton, Massachusetts 02146. Einstein 1971. Subspecialty, endocrinology. Board certified (IM). Group, partnership, or geographic (full time). Available July 1978.

John J. Halpin, M.D., 1089 Elmore Avenue, Columbus, Ohio 43224. Georgetown 1971. Subspecialty, hematology/oncology. Board certified (IM). Group or partnership. Available July 1978.

Bruce E. Sherling, M.D., 28-B Warren Drive, Edison 08817. NYU 1973. Subspecialty, pulmonary diseases. Board certified (IM). Group or hospital-based. Available July 1978.

Yune-Gill Jeong, M.D., 6-B Booker Creek Apt., Chapel Hill, North Carolina 27514. Chun Nam (Korea) 1970. Subspecialty, pulmonary medicine. Board certified (IM). Hospital-based or geographic full-time pulmonary subspecialist. Available July 1978.

Abdul Rashid Gangoo, M.D., 4 Fairhavenmall, Apt. 14-E, Mineola, New York 11501. University of Kashmir (India) 1969. Subspecialty, infectious diseases. Board eligible (IM). Solo, partnership, group, public health, emergency room. Available July 1978.

Raja G. Bhat, M.D., 1806 Coachmen East, Lindenvold 08021. Christian Medical College, Vellore (India) 1972. Solo, partnership, group. Available July 1978.

Navinchandra M. Amin, M.D., 36 Oakville Drive, Apt. 1-A, Pittsburgh, Pennsylvania 15220. Grant Medical College, Bombay (India) 1961. Subspecialty, cardiovascular diseases. Board certified (IM). Group, partnership, institution. Available.



Marvin B. Padnick, M.D., 38 Steamboat Road, Great Neck, New York 11024. Rush Medical College 1973. Subspecialty, cardiovascular diseases. Partnership or group. Available June 1978.

Chun Wen Yang, M.D., 23 Ashwood Drive, Livingston 07039. Kaohsiung (Taiwan) 1969. Subspecialty, hematology/oncology. Board certified (IM). Group. Available July 1978.

Uday V. Gupte, M.D., 1012 Clintonville Street, White-stone, New York 11357. T.N. Medical College, Bom-bay (India). Subspecialty, gastroenterology. Board certified (IM). Partnership or group. Available Janu-ary 1978.

Gerald Einaugler, M.D., 2270 Ocean Avenue, Brook-lyn, New York 11229. University of Bologna (Italy) 1975. Board eligible. Solo, partnership, group. Avail-able July 1978.

M. Ganesharajah, M.D., 50 South Munn Ave., Apt. 420, East Orange 07018. Ceylon 1970. Subspecialty, nephrology. Board eligible. Group, partnership, solo. Available.

Robert E. Greenspan, M.D., 1240 Mulford Road, Columbus, Ohio 43212. University of Maryland 1971. Group, partnership, research. Available July 1978.

Barry Elliot Field, M.D., 4461 Pacific Coast Highway, Apt. C-205, Torrance, California 90505. Einstein. Subspecialty, gastroenterology. Board certified (IM). Group or partnership. Available September 1978.

Hong Joon Kim, M.D., 2014 S. 102nd Street, Apt. 109-C, West Allis, Wisconsin 53227. Seoul National University (Korea) 1970. Board eligible. Partnership or group. Available July 1978.

Myron A. Shoham, M.D., MOQ 3011, Camp Lejeune, North Carolina 28542. Boston University 1971. Sub-specialty, gastroenterology. Board certified (IM). Partnership or group. Available August 1978.

Stephen E. Weinberg, M.D., 663 Cumberland Avenue, Syracuse, New York 13210. Hahnemann 1971. Sub-specialty, cardiology. Board certified (IM). Group, partnership, hospital-based. Available July 1978.

Donald C. Brennan, M.D., 3351 South Port Drive, Sacramento, California 95826. SUNY (Downstate). Subspecialty, hematology/oncology. Board certified (IM). Group or partnership. Available July 1978.

Charles W. Werner, M.D., 151-68 11th Avenue, Whitestone, New York 11357. Bologna (Italy) 1970. Subspecialty, gastroenterology. Board eligible (IM). Group, partnership, solo. Available July 1978.

Ramesh K. Gandhi, M.D., 2210 Mattis Drive, Dayton, Ohio 45439. Amritsar (India). Subspecialty, gastro-enterology. Board certified (IM). Group, partnership, solo. Available July 1978.

John J. Cassel, M.D., 101 Valley Drive, Bolingbrook, Illinois 60439. Jefferson 1973. Subspecialties, cardiol-ogy, pulmonary medicine. Board certified (IM). Any type practice. Available July 1978.

Anilkumar Raotibhai Patel, M.D., Deborah Heart and Lung Center, Browns Mills, New Jersey 08015. Makerere (Uganda) 1970. Subspecialty, cardiology. Board certified (IM). Group, partnership, institu-tional. Available July 1978.

Barry Sanders, M.D., 9113 Cloisters East, Richmond, Virginia 23229. SUNY (Buffalo) 1973. Subspecialty, gastroenterology. Board certified (IM). Group, part-nership. Available July 1978.

Joseph I. Matthews, M.D., 4708 Iris Street, Rockville, Maryland 20853. Creighton 1969. Subspecialty, pulmonary medicine. Board certified (IM). Group. September 1978.

Bgoki N. Kuppuswamy, M.D., 7507 Riverdale Road, Apt. 2057, New Carrollton, Maryland 20784. Madras (India) 1972. Subspecialty, nephrology. Board eligible (IM). Group, partnership, institutional. Available July 1978.

Thomas Y. Ko, M.D., 131 Sharbot Drive, Pittsburgh, Pennsylvania 15237. Taipei (Taiwan) 1972. Sub-specialty, cardiology. Board eligible (IM). Group, partnership, solo (hospital-based). Available July 1978.

NEPHROLOGY—Ralph J. Carciana, M.D., 2556 Alderney Lane, Winston-Salem, North Carolina 27103. Tufts 1974. Board eligible. Group. Available July 1978.

NEUROLOGY—Lester Hershman, M.D., 500 East 85th Street, Apt. 3-F, New York, New York 10028. Mt. Sinai (NYC) 1974. Board eligible. Group, partnership, solo. Available July 1978.

Peter J. Barbour, M.D., 1711-A Marshall Court, Los Altos, California 94022. Temple 1974. Group or partnership. Available July 1978.

Wook Chung, M.D., 950 49th Street, Apt. 6-J, Brook-lyn, New York 11219. Catholic Medical College (Korea) 1967. Group, partnership, or solo. Available July 1978.

N. D. Karmali, M.D., c/o Daniel Boone Clinic, Har-lan, Kentucky 40831. T.N. Medical College, Bombay (India) 1971. Board eligible. Partnership or group. Available January 1978.

Harold P. Wittcoff, M.D., 8842 Meadowbrook Drive, Pensacola, Florida 32501. Georgetown 1969. Board eligible. Group or partnership. Available.

OPHTHALMOLOGY—Allan Stuart Markowitz, M.D., 3535 Rochambeau Avenue, Apt. 2-L, Bronx, New York 10467. Einstein 1974. Board eligible. Group, partnership, solo, or institutional. Available July 1978.

ORTHOPEDIC SURGERY—Jeffery H. Phillips, M.D., 3450-23 Wayne Avenue, Bronx, New York 10467. Einstein 1974. Group or partnership. Available July 1978.

Alfred C. Lotman, M.D., 1640 Johnson Avenue, Apt. 162-B, Petersburg, Virginia 23801. Tulane 1971. Board certified. Group. Available.

OTOLARYNGOLOGY—Jeffrey M. Rosenbaum, M.D., 1575 Center Avenue, Apt. 3-D, Fort Lee 07024. Albany 1973. Partnership or group. Available July 1978.

PATHOLOGY—Moo Keun Lee, M.D., 120 Randolph Road, Apt. #48, Plainfield 07060. Yonsei (Korea) 1968. Group or partnership. Available July 1978.

PEDIATRICS—Susan R. De Castro, M.D., East 16th Street, Alma, Georgia 31510. Far Eastern (Philippines) 1965. Board eligible. Group, partnership, solo, or public health. Available April 1978.

Winston A. Rajasingham, M.D., 2620 Ocean Parkway, Apt. 4-F, Brooklyn, New York 11235. Sri Lanka (Ceylon) 1968. Group, partnership, associate. Available.

Joseph M. Chettupuzha, M.D., 21 Heywood Street, Apt. 2-D, Worcester, Massachusetts 01604. KMC (India) 1973. Group or partnership. Available July 1978.

Leo P. Pajarillo, M.D., 2503-A Atlas Drive, Rome, New York 13440. Cebu (Philippines) 1968. Board eligible. Group, partnership, solo. Available July 1978.

SURGERY—Martin Gewecke, M.D., 143-11 Kirkbride Road, Voorhees Township 08043. Munich 1967. Board

eligible. Group, partnership, hospital. Available January 1978.

Manuel S. DiJamco, M.D., 1432 Arch Street, Apt. B-201, Norristown, Pennsylvania 19401. Manila Central University (Philippines) 1952. Group, partnership, or solo. Available July 1978.

Yahya O. Labban, M.D., 9303 Hammerly, Apt. 703, Houston, Texas 77080. French Faculty, Beirut (Lebanon) 1955. Subspecialty, general practice. Board eligible (Surgery) Group, solo. Available.

UROLOGY—Louis D'Amico, M.D., 1061 Renfield Road, Cleveland Heights, Ohio 44121. Hahnemann 1973. Group, partnership, solo. Available July 1978.

V. R. Goli, M.D., 195 Deveron Crescent, London, Ontario, Canada N52 4J4. Guntur (India) 1962. Board eligible. Group, partnership, or solo. Available July 1978.

E. Unnikrishnan, M.D., 1895 Belmore Road, East Cleveland, Ohio 44112. Calicut (India). Group, partnership, solo. Available.

Michael Barr, M.D., 3450-10 Wayne Avenue, Bronx, New York. SUNY (Downstate) 1972. Solo or partnership. Available July 1978.

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## *Personal Item*

### **Dr. Haycock Graduated from U.S. Army War College**

Christine E. Haycock, M.D., of Newark, a colonel in the United States Army Reserve, has just been graduated from the United States Army War College as its first female President. Dr. Haycock has an impressive list of "firsts" to her credit, including the first female physician to complete studies at the War College, the first female to intern at Walter Reed Medical Center in 1952, and the first female to hold a major command in the state of New Jersey, and only the third female to hold a command in the United States.

Dr. Haycock is presently commander of the 322nd General Hospital, Kearny, Associate Professor of Surgery at the New Jersey Medical School, and Director of the Surgical Trauma Service at the Martland Hospital Unit, both affiliated with the College of Medicine and Dentistry of New Jersey in Newark.

In addition to being a diplomate of the American Board of Surgery and a Fellow of the American College of Surgeons, Doctor Haycock is member of many medical organizations, including of the American College of Emergency Physicians and the University Association of Emergency Medicine. She is also a member of the American College of Sports Medicine, and has written a number of papers on topics in sports medicine, as well as on trauma.

# CLINICAL NOTE

## Plastic Repair of the Sphincter of Oddi: A New Variation

Stanley Edeiken, M.D., Neptune\*

The technique of transduodenal plastic repair of the sphincter of Oddi described by Jones and Smith<sup>1</sup> in 1952 has been the basic operation used by the majority of surgeons. Although this procedure gave very satisfactory results to 27 of my patients since 1964, one patient had post-operative pancreatitis with development of a duodenal fistula which healed after adequate drainage. Recently, I developed a variation of the technique which I believe will avoid the serious complication of pancreatitis due to injury of the pancreatic duct.

The technique which has been described previously elsewhere<sup>2</sup> is as follows:

After common duct exploration, the duodenum is mobilized by a Kocher maneuver. A No. 5 Bakes dilator is inserted in the common duct and pushed firmly against the ampulla, which in turn is pushed anteriorly. The ampulla can then be easily palpated through the anterior wall of the duodenum. A short longitudinal duodenotomy is made over this region and the ampulla easily is delivered through a small duodenotomy incision by manipulating the Bakes dilator.

The lumen of the ampulla is identified, and a sphincterotomy is performed anterolaterally to avoid injuring the pancreatic duct, which usually enters posteromedially. The sphincter is first clamped with two mosquito hemostats, and then divided between the clamps. The Bakes dilator is withdrawn and any impacted stones removed. The orifice of the pancreatic duct, identified posteriorly, is avoided. Additional mosquito hemostats are placed farther up the lumen and the incision in the sphincter is continued upward. Eventually, the posterior wall of the duodenum and the intramural or anterior wall of the common duct are clamped and divided. This clamping and dividing continues proximally until the desired lumen size is obtained. Jones excises a wedge of tissue between the clamps, but usually I have not done this.

Simple sutures of 4-0 silk are placed around the clamps, and at the apex of the incision, approximating the duodenal and common duct walls. These sutures should be placed several millimeters apart to prevent a post-operative duodenal leak. The sphincteroplasty incision should be as long as the diameter of the common duct but no longer than two centimeters.

\*Dr. Edeiken is a member of the surgical staff of Jersey Shore Medical Center, Neptune.



Figure 1 — Completed sphincter repair — usual technique.

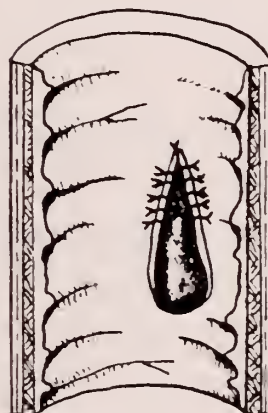


Figure 2 — Completed sphincter repair — new variation.

The change in technique was stimulated by two experiences performing transduodenal sphincteroplasty. The first incident involved a patient whose pancreatic duct entered the ampulla of Vater one millimeter away from the medial clamp of the first set of clamps which were placed on the sphincter. The other patient had an anomalous entrance of the pancreatic duct into the *lateral* wall of the ampulla of Vater. In the latter instance the transduodenal sphincteroplasty was performed without choledochostomy and the pancreatic duct, rather than the common bile duct, was entered with a hemostat. After opening and suturing the pancreatic duct the anomaly was recognized. If the procedure had been performed with the guidance of a Bakes dilator through a choledochostomy, the pancreatic duct would have been occluded by the sutures placed around the lateral hemostat on the distal 10 millimeters of the sphincter.



Therefore, to avoid the grave error of occluding the pancreatic duct, sutures placed in the distal 10 millimeters of the sphincter are omitted. This resembles a sphincterotomy but differs in that the proximal 1.0 cm of the sphincter is cut and sutured as one does with the Jones-Smith sphincteroplasty<sup>1</sup>. In a recent article, Jones<sup>3</sup> stated that the pancreatic duct usually entered the common duct and *always* on its medial side. It is possible that lateral entrance of the pancreatic duct was not recognized and pancreatitis resulted.

#### Comment

This operative variation has been performed on four patients without complication. Although

the author's series does not confirm this to be a safer procedure than the standard technique, I believe that the incidence of duodenal leakage will be no different than the standard technique and that the incidence of injury to the pancreatic duct will be lower. Since there is no price to pay for this change, it is justified and hopefully will prove its worth in the future.

#### References

1. Jones SA, Smith LL: Transduodenal sphincteroplasty for recurrent pancreatitis. *Ann Surg* 136:937-947, 1952.
2. Knecht JW, Edeiken S: Transduodenal sphincteroplasty: An operative technique. *Surg Digest* 7:17-19, 1972.
3. Jones SA: Sphincteroplasty (not sphincterotomy) in treatment of biliary tract disease. *Surg Clin N A* 53:1123-1137, 1973.

## PATRONIZE OUR ADVERTISERS

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## ANNOUNCEMENTS

### Cardiology and Hematology Seminar

Under the sponsorship of The Children's Hospital of Philadelphia, a seminar on cardiology and hematology will be held on January 13 and 14 at the hospital (34th Street and Civic Center Boulevard). The program is designed to familiarize the practicing pediatrician and family practitioner with recent advances in cardiology and hematology. Included will be case presentations, didactic lectures, and panel discussion. A fee will be charged and application has been made for credit in Category 1 of the AMA Physician's Recognition Award. For information please communicate with Patrick S. Pasquariello, Jr., M.D., The Children's Hospital, Philadelphia at the above address.

### Clinical Practice of Nuclear Medicine

The American College of Nuclear Medicine, New Jersey Chapter, announces the following symposia in its series on advances in the clinical practice of nuclear medicine.

- |         |   |
|---------|---|
| Jan. 11 | Liver Imaging—Middlesex General Hospital, New Brunswick |
| March 8 | Lung Imaging—(location to be announced)                 |
| May 10  | Thyroid Imaging—(location to be announced)              |

All sessions convene at 7:30 p.m. Application has been made for credit in Category 1 of the Physician's Recognition Award. For further information please communicate with the American College of Nuclear Medicine, 2424 Morris Avenue, Union, New Jersey 07083.

# THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

Publisher: The Medical Society of New Jersey  
P.O. Box 904  
Trenton, N.J. 08605

Advertising Representative: United Media Associates  
16 Bruce Park Avenue  
Greenwich, Conn. 06830  
(203) 661-9702

## General Information

### 1. Issuance:

- a. Frequency: Monthly
- b. Issue date: 10th of month.
- c. Mailing date: 10th of month

### 2. Established: 1904

### 3. Organization Affiliation:

Official publication of  
The Medical Society of New Jersey.

### 4. Circulation Data:

a. Controlled circulation to all members of The Medical Society of New Jersey. Members' subscription (\$5) is included in Society dues. Rates for non-members \$10, outside USA add \$2.50 for postage. Single copies \$1.

b. Annual percentage of subscription renewals: 100% of members.

c. Number of issues sent after subscription expiration: None.

### 5. Special Issues: Convention (April); Annual Transactions (July or August); Index (December)

6. **Editorial Content:** Original scientific articles, special articles, case reports, editorials, medical news and meeting notices, trustees' minutes, communicable disease reports, state legislation, convention, medical insurance, PSRO, education, etc.

### 7. Requirements for Acceptance of New Professional Products for Advertising.

All advertising subject to Publication Committee approval.

### 8. Requirement for Advertising Clearance:

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### 9. Advertising Acceptance of Nonprofessional Products or Services:

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### 10. Policy on Placement of Advertising:

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### 11. Advertisers' Index: No.

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a. Availability of mailing list: Availability subject to approval by Board of Trustees.

b. Availability of editorial reprints: Please direct such requests to the Editor.

### 13. Staff:

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William A. Dwyer, Jr., M.D.; Bernard D. Pinck,  
M.D., Richard H. Rapkin, M.D. Assistant Editor:  
Marjorie D. Treptow; Executive Director: Vincent A.  
Maressa.

### 14. Circulation:

All members of the Medical Society of New Jersey.

### 15. Guaranteed Circulation:

All members of the Medical Society of New Jersey.

### 16. Circulation Verification:

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### 17. Rates Per Thousand:

Based on the 12-times rate of \$240 and circulation  
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# THE JOURNAL of The Medical Society of NEW JERSEY

Rate Card effective January 1977

## 18. Coverage and Market

a. Coverage: All members of The Medical Society of New Jersey, plus trade circulation of approximately 650 medical libraries, drug manufacturers, medical book publishers, medical abstract services, advertisers, advertising agencies, subscriptions. Circulation figures as of 6-1-77.

b. GP .....	3,130
IM .....	1,789
GS .....	1,374
OBG .....	775
PED .....	647
DERM .....	186
ALL .....	79
UROL .....	206
EMT .....	411
PSYCH .....	607
OPH .....	363
RETIRED .....	245
TOTAL .....	<u>9,812</u>

### c. Trade Circulation:

Non-member physicians  
Medical libraries  
Medical schools  
Drug manufacturers  
Medical book publishers  
Medical abstract services  
Advertisers  
Advertising agencies  
Subscriptions

Total approximately ..... 650

## 19. MEMBERSHIP CIRCULATION BY COUNTIES OF STATE OF NEW JERSEY

Atlantic .....	235
Bergen .....	1,208
Burlington .....	280
Camden .....	590
Cape May .....	53
Cumberland .....	142
Essex .....	1,888
Gloucester .....	117
Hudson .....	607
Hunterdon .....	76
Mercer .....	631
Middlesex .....	632
Monmouth .....	604
Morris .....	525
Ocean .....	238
Passaic .....	790
Salem .....	52
Somerset .....	180
Sussex .....	73
Union .....	832
Warren .....	69
Total .....	<u>9,812</u>

Guaranteed Circulation: 10,000



# THE JOURNAL of The Medical Society of NEW JERSEY

Rate Card effective January 1977

## ates

### 1. Issuance:

Frequency: Monthly

Issue Date: 10th of month

Mailing date: 10th of month.

### 1. Closing Dates for Space:

Reservations: 1st of month preceding month of issue

Cancellations: 6th of month preceding month of issue

### 2. Agency Commission: 15%

### 3. Cash Discount: 2%, 10 days.

### 4. Rates:

	1 time	3 times	6 times	12 times	
page	280	270	260	240	Classified: Available to member physicians only.
1/2 page	160	150	140	130	
1/4 page	75	70	65	60	
1/8 page	50	45	40	35	

### 25. Earned Rates:

Rates based on number of insertions used within one year, regardless of size. Space purchased by a parent company and subsidiaries is combined for accounting of earned rates.

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b. List of standard colors: AAAA standard red, green, blue, yellow, orange.

c. Matched Colors: \$130 plus earned black and white rate.

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e. 4-color rate: \$440 plus earned black and white rate.

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### 28. Inserts:

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a. Preferred position rates quoted on request and subject to availability.

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### 30. Miscellaneous:

a. Contract requirements: All contracts subject to publisher's approval.

b. Statement of guarantee of uniform rates and discounts to all advertisers using same amount and kind of space: No exceptions to published rates.

c. Concessions: None

d. Rates subject to change with 90 days notice. Contracts accepted with understanding that rates will be guaranteed for three months beyond last issue closed. In the event of rate increase, contracts may be terminated without penalty of short rate.

# THE JOURNAL of The Medical Society of NEW JERSEY

Rate Card effective January 1977

## Mechanical Requirements

THE JOURNAL is printed by offset.

Trim size: 8 x 11

### 31. Plate Sizes:

Page Unit	Dimensions
1 full page	7 x 10
½ horizontal	7 x 4⅞
½ vertical	3⅜ x 10
¼ horizontal	7 x 2⅜
¼ vertical	3⅜ x 4⅞
⅛ horizontal	7 x 1⅞
⅛ vertical	3⅜ x 2⅜

### 32. Bleed Size

Page Unit	Dimensions
1 full page	8⅞ x 11¼

### 33. Insert Requirements

Untrimmed size — 8¼ x 11¼

### 34. Paper Stock: Covers: 80-pound.

Inside pages: 60 pound.

### 35. Type of Binding: Perfect bound.

### 36. Halftone Screen: Up to 133 screen

### 37. Reproduction Requirements:

Black and white positives and 2-color advertisements: negatives, camera-ready mechanicals, and art work acceptable.

4-color: film negatives or positive separations and press proof.

Offset film negatives or positives on .002 or .004 stable base materials must have register marks, center marks, and trim marks clearly indicated. Each negative must be marked for color and be right reading emulsion side down.

### 38. Closing Dates:

a. Negatives or positives, camera ready mechanicals, and art work: 10th of the month preceding month of issue.

b. Publication set copy: 5th of month preceding month of issue.

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# MEETINGS OF MEDICAL INTEREST

This listing is compiled through the cooperation of the Committee on Medical Education of The Medical Society of New Jersey, the Academy of Medicine of New Jersey, the New Jersey Chapter of the American Academy of Family Physicians, and the Office of Continuing Medical Education of the College of Medicine and Dentistry of New Jersey. For information on accreditation, please contact the sponsoring organization(s), indicated by italics—last line of each item.

Nov.

## Daily Noontime Conferences

Hunterdon Medical Center, Flemington  
(*Hunterdon Medical Center and AAFP*)

## 12 Family Therapy

9 a.m.-5 p.m. — Holiday Inn, Livingston  
(*N.J. Center for Family Studies and AMNJ*)

## 12 CME Program

26 8-10 a.m. — Newcomb Hospital, Vineland  
(*University of Pennsylvania School of Medicine and AAFP*)

## 12 Seminar in Anesthesiology

8 a.m.-3:30 p.m. — Helene Fuld Medical Center  
Trenton  
(*Helene Fuld Medical Center*)

## Metastatic Cancer

12 9:30 a.m.-5 p.m. }  
13 9 a.m.-12:30 p.m. } — Marriott Hotel, Saddle Brook  
(*American Cancer Society, NJ Division and AMNJ*)

## 13 Pre-Hospital and ER Relationships

9:15 a.m.-4 p.m. — Holiday Inn, North Brunswick  
(*Inter-Agency Commission on Emergency Medical Care and AMNJ*)

## 14 Neuroscience Conferences

21 11:30 a.m.-12:30 p.m. — Bergen Pines Co. Hospital  
28 Paramus  
(*Bergen Pines County Hospital and AMNJ*)

## 15 Northern Regional Chest Conferences

7:30-9:30 p.m. — Martland Hospital, Newark  
(*New Jersey Thoracic Society and AMNJ*)

## 15 Diabetes

12 noon — St. Mary's Hospital, Orange  
(*AMNJ and AAFP*)

## 15 Kidney Function and Anesthesia

8-9 p.m. — Ramada Inn, Clark  
(*NJ State Society of Anesthesiologists and AMNJ*)

## 16 Significance of Adrenals in Hypertension

1-2 p.m. — VA Hospital, Lyons  
(*VA Hospital and AMNJ*)

## 16 Special Problems in Neurology

7-10 p.m. — VA Hospital, East Orange  
(*VA Hospital and AMNJ*)

## 16 Management of Acute Drug Abuse Emergencies

1 p.m. — Trenton Psychiatric Hospital  
(*AMNJ and AAFP*)

## 16 Common Medical Problems for the Family Physician

8 a.m. — S. Ocean County Hospital, Manahawkin  
(*Burlington County Memorial Hospital and AMNJ*)

## 16 Arthritis: New Agents

1 p.m. — Christ Hospital, Jersey City  
(*Christ Hospital*)

## 16 Cardiology Conferences

4-6 p.m. — Rutgers Medical School, Piscataway  
(*CMDNJ and AMNJ*)

## 16 Courses for Psychiatrists

8-10 p.m. — Hackensack Hospital  
(*New Jersey Psychoanalytic Society and AMNJ*)

## 16 CME Program for Family Practitioners

9-11 a.m. — West Jersey Hospital, Voorhees  
(*West Jersey Hospital and AAFP*)

## 16 Forensic Topics

1:15 p.m.-2:45 p.m. — Marlboro Psychiatric Hospital  
(*Marlboro Psychiatric Hospital and AMNJ*)

## 16 Multidisciplinary Approach to Cancer

23 2-4 p.m. — Newark Beth Israel Medical Center  
30 (*Newark Beth Israel Medical Center and AMNJ*)

## 16 Clinical Hypnosis

1-5 p.m. — Ramada Inn, Clark  
(*Rutgers Medical School and AMNJ*)

## 16 Internal Medicine and Therapeutics

23 9-11 a.m. — Middlesex General Hospital,  
30 New Brunswick  
(*Middlesex General Hospital and AMNJ*)

## 16 Environmental Cancer

23 Galactorrhea  
30 Host Factors — Influencing the Impact of Disease  
9:30-11:30 a.m. — Bergen Pines County Hospital  
(*Bergen Pines County Hospital and AMNJ*)

## 16 Continuing Medical Education Program

23 10:30-11:30 a.m. — Clara Maass Memorial Hospital  
30 Belleville  
(*Clara Maass Memorial Hospital and AAFP*)

## 16 Diabetes Insipidus

23 Acute and Chronic Hepatitis  
30 Neurology of Old Age  
9-11 a.m. — Riverview Hospital, Red Bank  
(*Riverview Hospital and AMNJ*)

## 16 Psychiatry

30 1-3 p.m. — Ancora Psychiatric Hospital, Hammonton  
(*Ancora Psychiatric Hospital and AMNJ*)



- 17 **Management of Cardiac Patients**  
6:15 p.m. — Bridgeton Hospital  
(*Bridgeton Hospital*)
  - 17 **Sexual Incompatibility — Causes and Cures**  
5-6:30 p.m. — Somerset Hospital, Somerville  
(*Somerset Hospital and AMNJ*)
  - 17 **Ovarian Carcinoma**  
3:30-4:30 p.m. — Burlington County Memorial Hospital, Mount Holly  
(*Burlington Co. Memorial Hospital*)
  - 17 **Pediatric Allergy Course**
  - 24 11 a.m.-12 noon — Children's Hospital of Newark  
(*Children's Hospital of Newark and AMNJ*)
  - 17 **Current Concepts in Modern Biology**  
4-6 p.m. — Institute for Medical Research, Camden  
(*Institute for Medical Research and AMNJ*)
  - 17 **Management of Geriatric Psychiatric Disorders**  
11 a.m.-12 noon — Greystone Park Psychiatric Hospital  
(*Greystone Park Psychiatric Hospital and AMNJ*)
  - 17 **Assertive Training**  
9:30 a.m.-3:30 p.m. — Trenton Psychiatric Hospital  
(*Trenton Psychiatric Hospital and AMNJ*)
  - 18 **Cardiac Rehabilitation**  
12 noon — Freehold Area Hospital  
(*AMNJ and AAFP*)
  - 18 **Psychiatric Lecture Series**  
1:30-5 p.m. — Trenton Psychiatric Hospital  
(*Trenton Psychiatric Hospital and AMNJ*)
  - 19 **Gynecologic Oncology Seminar**  
9 a.m.-1:30 p.m. — Clara Maass Memorial Hospital, Belleville  
(*Clara Maass Memorial Hospital and AMNJ*)
  - 23 **Headache**  
3:15 p.m. — Fair Oaks Hospital, Summit  
(*AMNJ and AAFP*)
  - 23 **Radiology**  
8-9 a.m. — So. Ocean County Hospital, Manahawkin  
(*Burlington County Memorial Hospital and AAFP*)
  - 25 **G.I. Bleeding**  
12:30 p.m. — Hamilton Hospital, Trenton  
(*AMNJ and AAFP*)
  - 28 **Intra-Aortic Balloon Pumping**  
8 p.m. — Warren Hospital, Phillipsburg  
(*AMNJ and AAFP*)
  - 29 **Clinical Pathological Conferences**  
1-2 p.m. — Trenton Psychiatric Hospital  
(*Trenton Psychiatric Hospital and AMNJ*)
  - 29 **The Psychiatrist in Community Mental Health Center**  
1:30-3:30 p.m. — Trenton Psychiatric Hospital  
(*Trenton Psychiatric Hospital and AMNJ*)
  - 29 **Psychopharmacology in the Geriatric Patient**  
1-3:30 p.m. — Camden County Psychiatric Hospital, Lakeland  
(*Camden County Psychiatric Hospital and AMNJ*)
  - 29 **Nuclear Medicine for the Practitioner**  
8-9 a.m. — Garden State Community Hospital  
(*Garden State Community Hospital and AMNJ*)
  - 30 **Hypertension II**  
1-3 p.m. — Christ Hospital, Jersey City  
(*Christ Hospital and AMNJ*)
  - 30 **Fall Refresher Course**  
9:15 a.m.-4:45 p.m. — John F. Kennedy Medical Center, Edison  
(*AAFP and AMNJ*)
  - 30 **Arthritis**  
3 p.m. — Ancora Psychiatric Hospital, Hammonton  
(*AMNJ and AAFP*)
  - 30 **Recent Advances in Myeloma**  
1-2 p.m. — VA Hospital, Lyons  
(*VA Hospital and AMNJ*)
  - 30 **EKG for the Practitioner**  
9-11 a.m. — West Jersey Hospital, Voorhees  
(*West Jersey Hospital and AAFP*)
- Dec.
- Daily Noontime Conferences**  
Hunterdon Medical Center, Flemington  
(*Hunterdon Medical Center and AAFP*)
- 1 **Care of the Aged Post-Stroke Patient**  
2-4 p.m. — Daughters of Miriam Center, Clifton  
(*Daughters of Miriam Center for the Aged, AMNJ and AAFP*)
  - 1 **Infectious Disease Course**  
8:30-9:30 a.m. — Somerset Hospital, Somerville  
(*Somerset Hospital and AMNJ*)
  - 1 **Bleeding Diseases**  
11 a.m. — Greystone Park Psychiatric Hospital  
(*AMNJ and AAFP*)
  - 1 **Pediatric Seminar**  
1-5 p.m. — Endocrinology Seminar  
8-9 p.m. — Ethical Problems in Pediatrics — Ramada Inn, Clark  
(*NJ Chapter, American Academy of Pediatrics and AMNJ*)
  - 1 **Pediatric Allergy Course**
  - 8 11 a.m.-12 noon — Children's Hospital of Newark  
15 (*Children's Hospital of Newark and AMNJ*)  
22
  - 1 **Inflammatory Bowel Disease**
  - 8 **Blood Transfusions**
  - 15 **Syphilis and the Clinician**  
3:30-4:30 p.m. — Burlington Co. Memorial Hospital, Mount Holly  
(*Burlington Co. Memorial Hospital*)
  - 1 **Current Concepts in Modern Biology**
  - 8 4-6 p.m. — Institute for Medical Research, Camden  
15 (*Institute for Medical Research and AMNJ*)
  - 2 **Psychiatric Lecture Series**
  - 9 1:30-5 p.m. — Trenton Psychiatric Hospital  
(*Trenton Psychiatric Hospital and AMNJ*)

- 2**    **Thanatology**  
8:30 a.m. — United Hospitals of Newark  
(*AMNJ and AAFP*)
- 2**    **Diabetes**  
12 noon — Freehold Area Hospital  
(*AMNJ and AAFP*)
- 3**    **Seminar in Anesthesiology**  
9 a.m.-3 p.m. — Rutgers Medical School, Piscataway  
(*Educational Council for Anesthesiology of NJ and AMNJ*)
- 3**    **Annual Meeting — American College of Surgeons**  
9 a.m.-4:30 p.m. — New Jersey Medical School  
Newark  
(*American College of Surgeons and AMNJ*)
- 5**    **Neuroscience Conference**
- 12**    11:30 a.m.-12:30 p.m. — Bergen Pines County Hospital
- 19**    Paramus  
(*Bergen Pines County Hospital and AMNJ*)
- 5**    **Bleeding Diseases**  
11 a.m. — Community Memorial Hospital, Toms River  
(*AMNJ and AAFP*)
- 5**    **Psychiatric Seminar**  
8-10 p.m. — 192 Chittenden Rd., Clifton  
(*Essex Psychiatric Seminar and AMNJ*)
- 6**    **Community Medicine**  
9:30-10:30 a.m. — Overlook Hospital, Summit  
(*Overlook Hospital and AAFP*)
- 6**    **Congenital Diseases**  
9 a.m. — Freehold Area Hospital  
(*AMNJ and AAFP*)
- 6**    **Continuing Education Lectures in Psychiatry**
- 14**    1-3 p.m. — Ancora Psychiatric Hospital, Hammonton  
(*Ancora Psychiatric Hospital and AMNJ*)
- 6**    **Nuclear Medicine for the Practitioner**
- 13**    8-9 a.m. — Garden State Community Hospital  
Marlton  
(*Garden State Community Hospital and AMNJ*)
- 7**    **Lectures in Obstetrics/Gynecology**  
6-10 p.m. — 141 S. Harrison St., E. Orange  
(*New Jersey Medical School, and AMNJ*)
- 7**    **Pitfalls of Laboratory Screening**
- 14**    **Polycythemia Vera**
- 21**    **Aspirin for the Limping Brain**
- 28**    **Clinical Pathology Conference**  
9:30-11:30 a.m. — Bergen Pines County Hospital  
Paramus  
(*AMNJ and AAFP*)
- 7**    **Cardiology Conferences**  
4-6 p.m. — Rutgers Medical School, Piscataway  
(*CMDNJ and AMNJ*)
- 7**    **Cerebral Vascular Accident**  
3:15 p.m. — Fair Oaks Hospital, Summit  
(*AMNJ and AAFP*)

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- 7 **New Methods of Endocrine Testing**  
1 p.m. — Christ Hospital, Jersey City  
(*AMNJ and AAFP*)
- 7 **Multidisciplinary Approach to Cancer**
- 14 2-4 p.m. — Newark Beth Israel Medical Center
- 21 (*Newark Beth Israel Medical Center and AMNJ*)
- 7 **EKG for the Practitioner**
- 14 9-11 a.m. — West Jersey Hospital, Voorhees
- 21 (*West Jersey Hospital and AAFP*)
- 28
- 7 **Cancer Chemotherapy Update**
- 14 **Sex Therapy**
- 28 **Traumatic Surgery and Shock**  
9-11 a.m. — Riverview Hospital, Red Bank  
(*Riverview Hospital and AMNJ*)
- 7 **Continuing Medical Education Program**  
10:30-11:30 a.m. — Clara Maass Memorial Hospital  
Belleville  
(*Clara Maass Memorial Hospital and AAFP*)
- 7 **Peer Evaluation of Medical Care**  
7:30-9:30 p.m. — 377 So. Harrison St., East Orange  
(*Journal Club of Greater Newark and AMNJ*)
- 8 **Hard-to-Manage Diabetes**  
5-6:30 p.m. — Somerset Hospital, Somerville  
(*Somerset Hospital and AMNJ*)
- 8 **Clinical Evaluation of Dangerousness**
- 15 **Case Presentation**
- 22 **Treatment of the Schizophrenic Family**
- 29 **Treatment of the Schizophrenic Family**  
11-12 Noon — Greystone Park Psychiatric Hospital  
(*Greystone Park Psychiatric Hospital and AMNJ*)
- 9 **Hyperlipoproteinemia**  
11 a.m.-12:30 p.m. — Saddle Brook General Hospital  
(*Saddle Brook General Hospital and AMNJ*)
- 10 **CME Program**  
8-10 a.m. — Newcomb Hospital, Vineland  
(*University of Pennsylvania School of Medicine and AAFP*)
- 13 **Obesity and Hypoglycemia**  
8 p.m. — Paul Kimball Hospital  
(*AMNJ and AAFP*)
- 13 **Medical/Legal Aspects of Medicine and Surgery**  
9 p.m. — Bayonne Hospital  
(*AMNJ and AAFP*)
- 14 **Clinical E.E.G.**  
1 p.m. — Christ Hospital, Jersey City  
(*Christ Hospital*)
- 14 **Psychopharmacology**  
1:30-3:30 p.m. — Trenton Psychiatric Hospital  
(*Trenton Psychiatric Hospital and AMNJ*)
- 14 **Treatment and Prevention of Violence Among Youth**  
8:30-10:30 p.m. — Guido's Restaurant, Hackensack  
(*North Jersey Psychiatric Society and AMNJ*)



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- 14 **Management of Hyperlipidemias**  
9 a.m.-4:30 p.m. — Rutgers Medical School  
Piscataway  
(*CMDNJ, AMNJ and AAFP*)
  - 15 **Endoscopy**  
6:15 p.m. — Bridgeton Hospital  
(*Bridgeton Hospital*)
  - 16 **Management of Hepatitis**  
5 p.m. — Salem County Medical Society  
(*AMNJ and AAFP*)
  - 19 **Surgical Management of Ulcerative Colitis**  
12 noon — Hospital Center at Orange  
(*AMNJ and AAFP*)
  - 20 **Disseminated Intravascular Coagulation**  
12 noon — St. Mary's Hospital, Orange  
(*AMNJ and AAFP*)
  - 21 **Common Medical Problems for the Family Physician**  
8 a.m. — S. Ocean County Hospital, Manahawkin  
(*Burlington County Memorial Hospital and AAFP*)
  - 21 **Suicidology**  
3:15 p.m. — Fair Oaks Hospital, Summit  
(*AMNJ and AAFP*)
  - 21 **Special Problems in Neurology**  
7-10 p.m. — VA Hospital, East Orange  
(*VA Hospital and AMNJ*)
  - 21 **Evaluating and Treating Essential Hypertension**  
1-2 p.m. — VA Hospital, Lyons  
(*VA Hospital and AMNJ*)
  - 27 **Clinical Pathological Conference**  
1-2 p.m. — Trenton Psychiatric Hospital  
(*Trenton Psychiatric Hospital and AMNJ*)
  - 28 **Radiology**  
8-9 a.m. — So. Ocean County Hospital, Manahawkin  
(*Burlington County Memorial Hospital and AAFP*)
  - 30 **Medical Care in Emergency Department**  
12:30 p.m. — Hamilton Hospital, Trenton  
(*AMNJ and AAFP*)
- Jan.**
- 2 **Medical Care in Emergency Department**  
8 p.m. — Community Memorial Hospital, Toms River  
(*AMNJ and AAFP*)
  - 3 **Peripheral Vascular Disease**  
11 a.m. — Greystone Park Psychiatric Hospital  
(*AMNJ and AAFP*)
  - 4 **Advances in Medicine**  
11 9:30-11 a.m. — Bergen Pines County Hospital, Paramus  
18 (*Bergen Pines County Hospital and AMNJ*)  
25
  - 4 **Cardiology Conferences**  
18 4-6 p.m. — Rutgers Medical School, Piscataway  
(*CMDNJ and AMNJ*)
  - 4 **New Developments in Scanning**  
3:15 p.m. — Fair Oaks Hospital, Summit  
(*AMNJ and AAFP*)
  - 4 **Psychiatric Aspects of Endocrinology**  
1 p.m. — Christ Hospital, Jersey City  
(*AMNJ and AAFP*)
  - 4 **Lectures in Obstetrics/Gynecology**  
6-10 p.m. — 141 S. Harrison St., E. Orange  
(*New Jersey Medical School and AMNJ*)
  - 4 **Psychiatry**  
18 1-3 p.m. — Ancora Psychiatric Hospital, Hammonton  
25 (*Ancora Psychiatric Hospital and AMNJ*)
  - 5 **Pediatric Allergy Course**  
12 11 a.m.-12 noon — Children's Hospital of Newark  
19 (*Children's Hospital of Newark and AMNJ*)  
26
  - 5 **Infectious Disease Course**  
8:30-9:30 a.m. — Somerset Hospital, Somerville  
(*Somerset Hospital and AMNJ*)
  - 5 **Current Concepts in Modern Biology**  
12 4-6 p.m. — Institute for Medical Research, Camden  
19 (*Institute for Medical Research and AMNJ*)  
26
  - 6 **Outpatient Management of Tuberculosis**  
8:30 a.m. — United Hospitals of Newark  
(*AMNJ and AAFP*)
  - 9 **Neuroscience Conferences**  
16 11:30 a.m.-12:30 p.m. — Bergen Pines County Hospital  
23 Paramus  
30 (*Bergen Pines County Hospital and AMNJ*)
  - 10 **Arthritis**  
12 noon — Hospital Center at Orange  
(*AMNJ and AAFP*)
  - 10 **Genetics**  
8 p.m. — Paul Kimball Hospital, Lakewood  
(*AMNJ and AAFP*)
  - 11 **Cerebral Vascular Disease**  
11:30 a.m. — Rahway Hospital  
(*AMNJ and AAFP*)
  - 11 **Fluid and Electrolyte Imbalance**  
1:30 p.m. — John E. Runnells Hospital, Berkeley  
Heights  
(*AMNJ and AAFP*)
  - 11 **The Irritable Bowel Syndrome**  
1-3:30 p.m. — VA Hospital, Lyons  
(*VA Hospital and AMNJ*)
  - 11 **Ischemic Heart Disease**  
1-3 p.m. — Christ Hospital, Jersey City  
(*Christ Hospital, AMNJ and AAFP*)
  - 14 **CME Program**  
28 8-10 a.m. — Newcomb Hospital, Vineland  
(*University of Pennsylvania School of Medicine and AAFP*)

- 15 **Special Problems in Neurology**  
7-10 p.m. — VA Hospital, East Orange  
(*VA Hospital and AMNJ*)
  - 15 **Shock**  
1-3 p.m. — Christ Hospital, Jersey City  
(*Christ Hospital and AMNJ*)
  - 17 **Northern Regional Chest Conferences**  
7:30-9:30 p.m. — Mountainside Hospital, Montclair  
(*New Jersey Thoracic Society and AMNJ*)
  - 17 **Pulmonary Embolism**  
12 noon — St. Mary's Hospital, Orange  
(*AMNJ and AAFP*)
  - 17 **Role of Anesthesiologists in an Ambulatory Surgical Unit**  
8-9 p.m. — Ramada Inn, Clark  
(*NJ State Society of Anesthesiologists and AMNJ*)
  - 18 **Special Problems in Neurology**  
7-10 p.m. — VA Hospital, East Orange  
(*VA Hospital and AMNJ*)
  - 18 **Advanced Life Support in CPR**  
1 p.m. — Trenton Psychiatric Hospital  
(*AMNJ and AAFP*)
  - 18 **Medical Humanism-Hospital Ethics**  
3:15 p.m. — Fair Oaks Hospital, Summit  
(*AMNJ and AAFP*)
  - 18 **Rectal Cancer**  
1-3 p.m. — Christ Hospital, Jersey City  
*Christ Hospital & AAFP*
  - 18 **Sleep Disorders—Part I**  
1-2 p.m. — VA Hospital, Lyons  
(*VA Hospital and AMNJ*)
  - 19 **Cellular Engineering in Medicine**  
5-6:30 p.m. — Somerset Hospital, Somerville  
(*Somerset Hospital and AMNJ*)
  - 19 **Advances in Nephrology**  
6:15 p.m. — Bridgeton Hospital  
(*Bridgeton Hospital*)
  - 24 **Allergy**  
8 p.m. — Warren Hospital, Phillipsburg  
(*AMNJ and AAFP*)
  - 25 **Evaluation of Hemorrhagic and Bleeding Disorders**  
1-2 p.m. — VA Hospital, Lyons  
(*VA Hospital and AMNJ*)
  - 27 **Cardiac Arrhythmias**  
12:30 p.m. — Hamilton Hospital, Trenton  
(*AMNJ and AAFP*)
- Feb.
- 1 **Cardiology Conferences**
  - 15 4-6 p.m. — Rutgers Medical School, Piscataway  
(*CMDNJ and AMNJ*)
  - 1 **Advances in Medicine**
  - 8 9:30-11 a.m. — Bergen Pines Hospital, Paramus  
(*Bergen Pines County Hospital and AMNJ*)
  - 22
- 1 **Cerebral Vascular Disease**  
1 p.m. — Christ Hospital, Jersey City  
(*AMNJ and AAFP*)
  - 1 **Total Joint Replacement and Bone Tumors**
  - 8 **Lithium and Affective Disorders**
  - 15 **Dermatologic Manifestations of Systemic Diseases**
  - 22 **Infection in the Compromised Host**  
9-11 a.m. — Riverview Hospital, Red Bank  
(*Riverview Hospital, AMNJ and AAFP*)
  - 1 **Psychiatry**
  - 7 1-3 p.m. — Ancora Psychiatric Hospital, Hammonton
  - 15 (*Ancora Psychiatric Hospital and AMNJ*)
  - 1 **Lectures in Obstetrics/Gynecology**  
6-10 p.m. — 141 S. Harrison St., E. Orange  
(*New Jersey Medical School and AMNJ*)
  - 2 **Current Concepts in Modern Biology**
  - 9 4-6 p.m. — Institute for Medical Research, Camden  
(*Institute for Medical Research and AMNJ*)
  - 16
  - 23
  - 2 **Care of the Aged Post-Hip Fracture Patient**  
2-4 p.m. — Daughters of Miriam Center, Clifton  
(*Daughters of Miriam Center for the Aged and AMNJ*)
  - 2 **Pediatric Allergy Course**
  - 9 11 a.m.-12 noon — Children's Hospital of Newark  
(*Children's Hospital of Newark and AMNJ*)
  - 16
  - 23
  - 2 **Infectious Disease Course**  
8:30-9:30 a.m. — Somerset Hospital, Somerville  
(*Somerset Hospital and AMNJ*)
  - 2 **Diabetes**  
11 a.m. — Greystone Park Psychiatric Hospital  
(*AMNJ and AAFP*)
  - 3 **Proper Uses of Blood Gases**  
8:30 a.m. — United Hospitals of Newark  
(*AMNJ and AAFP*)
  - 6 **Neuroscience Conferences**
  - 13 11:30 a.m.-12:30 p.m. — Bergen Pines County Hospital
  - 20 Paramus
  - 27 (*Bergen Pines County Hospital and AMNJ*)
  - 6 **Headache**  
8 p.m. — Community Memorial Hospital, Toms River  
(*AMNJ and AAFP*)
  - 7 **Neonatal Emergencies**  
9 a.m. — Freehold Area Hospital  
(*AMNJ and AAFP*)
  - 8 **Peripheral Vascular Disease**  
11:30 a.m. — Rahway Hospital  
1:30 p.m. — John E. Runnells Hospital, Berkeley Heights  
(*AMNJ and AAFP*)
  - 8 **Sleep Disorders—Part II**  
1-2 p.m. — VA Hospital, Lyons  
(*VA Hospital and AMNJ*)

- 8 **Psychiatric Malpractice**  
1:15-2:45 — Marlboro Psychiatric Hospital  
(*Marlboro Psychiatric Hospital and AMNJ*)
- 11 **CME Program**
- 25 8-10 a.m. — Newcomb Hospital, Vineland  
(*University of Pennsylvania School of Medicine and AAFP*)
- 11 **Seminar in Anesthesiology**  
9 a.m.-3 p.m. — New Jersey Medical School, Newark  
(*Educational Council for Anesthesiology of NJ and AMNJ*)
- 14 **Hyponitremia: Hypokalemia**  
8 p.m. — Paul Kimball Hospital, Lakewood  
(*AMNJ and AAFP*)
- 15 **Medical Humanism-Hospital Ethics**  
1 p.m. — Trenton Psychiatric Hospital  
(*AMNJ and AAFP*)
- 16 **Appropriate Workup for the Headache Patient**  
5-6:30 p.m. — Somerset Hospital, Somerville  
(*Somerset Hospital and AMNJ*)
- 16 **Problems in Biliary Tract Surgery**  
6:15 p.m. — Bridgeton Hospital  
(*Bridgeton Hospital*)
- 17 **Laboratory Interpretations**  
5 p.m. — Holiday Inn, Deepwater  
(*AMNJ and AAFP*)
- 17 **Endocrinology**  
12 noon — Freehold Area Hospital  
(*AMNJ and AAFP*)
- 20 **Current Surgical Techniques of Breast Cancer**  
12 noon — Hospital Center at Orange  
(*AMNJ and AAFP*)
- 20- **Endocrinology Symposium**
- 24 Nassau, Bahamas  
(*CMDNJ, AMNJ and VA Hospital, East Orange*)
- 21 **Northern Regional Chest Conferences**  
7:30-9:30 p.m. — St. Barnabas Hospital, Livingston  
(*New Jersey Thoracic Society and AMNJ*)
- 21 **Cancer of the Colon and Ovary**  
12 noon — St. Mary's Hospital, Orange  
(*AMNJ and AAFP*)
- 24 **Carcinoma of the Breast**  
12:30 p.m. — Hamilton Hospital, Trenton  
(*AMNJ and AAFP*)
- 28 **Drug Addiction**  
8 p.m. — Warren Hospital, Phillipsburg  
(*AMNJ and AAFP*)

#### Mar.

- 1 **Advances in Medicine**
- 8 9:30-11 a.m. — Bergen Pines County Hospital, Paramus  
(*Bergen Pines County Hospital and AMNJ*)
- 15
- 22
- 29
- 1 **Cardiology Conferences**
- 15 4-6 p.m. — Rutgers Medical School, Piscataway  
(*CMDNJ and AMNJ*)

- 1 **Proper Use of Blood Gases**  
11:30 a.m. — Rahway Hospital  
(*AMNJ and AAFP*)
- 1 **Fiberoptic Bronchoscopy**  
1 p.m. — Christ Hospital  
(*AMNJ and AAFP*)
- 1 **Courses for Psychiatrists**
- 8 8-10 p.m. — Hackensack Hospital  
(*NJ Psychoanalytic Society and AMNJ*)
- 15
- 22
- 29
- 1 **Immunology in Clinical Medicine**
- 8 **Controversies in Breast Cancer**
- 15 **Acupuncture**  
9-11 a.m. — Riverview Hospital, Red Bank  
(*Riverview Hospital, AMNJ and AAFP*)
- 1 **Psychiatry**
- 15 1-3 p.m. — Ancora Psychiatric Hospital  
(*Ancora Psychiatric Hospital and AMNJ*)
- 20
- 29
- 1 **Lectures in Obstetrics/Gynecology**  
6-10 p.m. — 141 S. Harrison St., E. Orange  
(*New Jersey Medical School and AMNJ*)
- 2 **Pediatric Allergy Course**
- 9 11 a.m.-12 noon — Children's Hospital of Newark  
(*Children's Hospital of Newark and AMNJ*)
- 16
- 23
- 2 **Current Concepts in Modern Biology**
- 9 4-6 p.m. — Institute for Medical Research, Camden  
(*Institute for Medical Research and AMNJ*)
- 16
- 23
- 2 **Immunology**  
11 a.m. — Greystone Park Psychiatric Hospital  
(*AMNJ and AAFP*)
- 2 **Infectious Disease Course**  
8:30-9:30 a.m. — Somerset Hospital, Somerville  
(*Somerset Hospital and AAFP*)
- 3 **Clinical Immunology**  
8:30 a.m. — United Hospitals of Newark  
(*AMNJ and AAFP*)
- 3 **Psychiatric Lecture Series**
- 10 1:30-5 p.m. — Trenton Psychiatric Hospital  
(*Trenton Psychiatric Hospital and AMNJ*)
- 17
- 6 **Neuroscience Conferences**
- 13 11:30 a.m.-12:30 p.m. — Bergen Pines County Hospital  
Paramus  
(*Bergen Pines County Hospital and AMNJ*)
- 20
- 27
- 6 **Obstructive Lung Disease**  
8 p.m. — Community Memorial Hospital, Toms River  
(*AMNJ and AAFP*)
- 8 **1977 Update on Traditional and New Venereal Disease**  
1-3 p.m. — Christ Hospital, Jersey City  
(*Christ Hospital, AMNJ, and AAFP*)
- 11 **CME Program**
- 25 8-10 a.m. — Newcomb Hospital, Vineland  
(*University of Pennsylvania School of Medicine and AAFP*)



- 14 **Cancer in New Jersey**  
8 p.m. — Paul Kimball Hospital, Lakewood  
(*AMNJ and AAFP*)
- 14 **Medical Care in Emergency Department**  
9 p.m. — Bayonne Hospital  
(*AMNJ and AAFP*)
- 14 **Medical/Legal Aspects of Medicine and Surgery**  
12 noon — Hospital Center at Orange  
(*AMNJ and AAFP*)
- 15 **Special Problems in Neurology**  
7-10 p.m. — VA Hospital, East Orange  
(*VA Hospital and AMNJ*)
- 15 **Diagnosis and Management of the Short Child**  
8:30-10 p.m. — 1257 Kensington Road, Teaneck  
(*Bergen Co. Chapter, American Medical Women's Assn. and AMNJ*)
- 15 **Proper Use of Antibiotics**  
1 p.m. — Trenton Psychiatric Hospital  
(*AMNJ and AAFP*)
- 15 **Drug Interactions**  
1-3 p.m. — Christ Hospital, Jersey City  
(*Christ Hospital, AMNJ and AAFP*)
- 16 **Sexual Counseling**  
6:15 p.m. — Bridgeton Hospital  
(*Bridgeton Hospital*)
- 16 **Emotional Management in Myocardial Infarction**  
5-6:30 p.m. — Somerset Hospital, Somerville  
(*Somerset Hospital and AAFP*)
- 17 **The Violent Patient**  
5 p.m. — Holiday Inn-Deepwater  
(*AMNJ and AAFP*)
- 17 **Diagnosis of Anemic Patient**  
12 noon — Freehold Area Hospital  
(*AMNJ and AAFP*)
- Edward Waters Gynecologic Conference**  
17 2-7 p.m. }  
18 8:30 a.m.-7 p.m. } Resorts International  
19 9 a.m.-12:30 p.m. } Hotel, Atlantic City  
(*CMDNJ, NJ Medical School and AMNJ*)
- 18 **Emergency '78 — Sports Medicine and Sports Emergencies**  
Ninth Annual Meeting — Valley Hospital, Ridgewood  
(*Valley Hospital*)
- 21 **Scanning**  
12 noon — St. Mary's Hospital, Orange  
(*AMNJ and AAFP*)
- 21 **Congestive Heart Failure**  
8:30 p.m. — Fair Lawn Memorial Hospital — Marriott Saddlebrook  
(*AMNJ and AAFP*)
- 21 **Northern Regional Chest Conferences**  
7:30-9:30 p.m. — St. Joseph's Hospital, Paterson  
(*New Jersey Thoracic Society and AMNJ*)
- 24 **Bleeding Disorders**  
12:30 p.m. — Hamilton Hospital, Trenton  
(*AMNJ and AAFP*)
- 28 **Hepatitis**  
8 p.m. — Warren Hospital, Phillipsburg  
(*AMNJ and AAFP*)
- 29 **Cerebral Vascular Disease**  
3 p.m. — Ancora Psychiatric Hospital, Hammonton  
(*AMNJ and AAFP*)
- Apr.  
3 **Neuroscience Conferences**  
10 11:30 a.m.-12:30 p.m. — Bergen Pines County Hospital,  
17 Paramus  
24 (*Bergen Pines County Hospital and AMNJ*)
- 3 **Suicidology**  
8 p.m. — Community Memorial Hospital, Toms River  
(*AMNJ and AAFP*)
- 4 **New Developments in Scanning**  
11 a.m. — Greystone Park Psychiatric Hospital  
(*AMNJ and AAFP*)
- 5 **Advances in Medicine**  
12 9:30-11 a.m. — Bergen Pines County Hospital, Paramus  
19 (*Bergen Pines County Hospital and AMNJ*)  
26
- 5 **Cardiology Conferences**  
19 4-6 p.m. — Rutgers Medical School, Piscataway  
(*CMDNJ and AMNJ*)
- 5 **Outpatient Management of Tuberculosis**  
11:30 a.m. — Rahway Hospital  
(*AMNJ and AAFP*)
- 5 **Suicidology**  
1 p.m. — Christ Hospital, Jersey City  
(*AMNJ and AAFP*)
- 5 **Courses for Psychiatrists**  
12 8-10 p.m. — Hackensack Hospital  
19 (*NJ Psychoanalytic Society and AMNJ*)  
26
- 5 **Lectures in Obstetrics/Gynecology**  
6-10 p.m. — 141 S. Harrison St., E. Orange  
(*New Jersey Medical School and AMNJ*)
- 6 **Current Concepts in Modern Biology**  
4-6 p.m. — Institute for Medical Research, Camden  
(*Institute for Medical Research and AMNJ*)
- 6 **Care of the Aged Arthritic Patient**  
2-4 p.m. — Daughters of Miriam Center, Clifton  
(*Daughters of Miriam Center for the Aged, AMNJ and AAFP*)
- 6 **Pediatric Allergy Course**  
13 11 a.m.-12 noon — Children's Hospital of Newark  
20 (*Children's Hospital of Newark and AMNJ*)  
27
- 6 **Infectious Disease Course**  
8:30-9:30 a.m. — Somerset Hospital, Somerville  
(*Somerset Hospital and AMNJ*)
- 7 **Infectious Diseases**  
8:30 a.m. — United Hospitals of Newark  
(*AMNJ and AAFP*)

- 7 Psychiatric Lecture Series**  
**14** 1:30-5 p.m. — Trenton Psychiatric Hospital  
**21** (*Trenton Psychiatric Hospital and AMNJ*)  
**28**
- 8 Third Annual Orthopedic Symposium**  
 Rutgers Medical School, Piscataway  
 (*AMNJ and AAFP*)
- 8 CME Program**  
**22** 8-10 a.m. — Newcomb Hospital, Vineland  
 (*University of Pennsylvania School of Medicine and AAFP*)
- 11 Fluid and Electrolyte Balance**  
 12 noon — Hospital Center at Orange  
 (*AMNJ and AAFP*)
- 12 Proper Use of Blood Gases**  
 1:30 p.m. — John E. Runnells Hospital, Berkeley Heights  
 (*AMNJ and AAFP*)
- 12 Psychiatry**  
**17** 1-3 p.m. — Ancora Psychiatric Hospital, Hammonton  
**19** (*Ancora Psychiatric Hospital and AMNJ*)  
**26**
- 18 Northern Regional Chest Conferences**  
 7:30-9:30 p.m. — Location to be announced  
 (*New Jersey Thoracic Society and AMNJ*)
- 18 Intra-Aortic Balloon Pumping**  
 12 noon — St. Mary's Hospital, Orange  
 (*AMNJ and AAFP*)
- 19 The Psychodynamics of Dental Practice**  
 9 a.m.-4 p.m. — New Jersey Dental School, Newark  
 (*AMNJ and CMDNJ*)
- 19 Special Problems in Neurology**  
 7-10 p.m. — VA Hospital, East Orange  
 (*VA Hospital and AMNJ*)
- 20 Nevi and Melanoma**  
 6:15 p.m. — Bridgeton Hospital  
 (*Bridgeton Hospital*)
- 21 Management of Hepatitis**  
 12 noon — Freehold Area Hospital  
 (*AMNJ and AAFP*)
- 22 Seminar in Anesthesiology**  
 9 a.m.-3 p.m. — Saint Barnabas Medical Center, Livingston  
 (*Educational Council for Anesthesiology of NJ and AMNJ*)
- 25 Medical/Legal Aspects of Medicine and Surgery**  
 8 p.m. — Warren Hospital, Phillipsburg  
 (*AMNJ and AAFP*)
- 26 General Problems in Psychiatry**  
 1:15-2:45 p.m. — Marlboro Psychiatric Hospital  
 (*Marlboro Psychiatric Hospital and AMNJ*)
- 28 Surgical Management of Inflammatory Bowel Disease**  
 12:30 p.m. — Hamilton Hospital, Trenton  
 (*AMNJ and AAFP*)

## May

- 1 Neuroscience Conferences**  
**8** 11:30 a.m.-12:30 p.m. — Bergen Pines County Hospital,  
**15** Paramus  
**22** (*Bergen Pines County Hospital and AMNJ*)
- 1 Arthritis**  
 8 p.m. — Community Memorial Hospital, Toms River  
 (*AMNJ and AAFP*)
- 1 Psychiatry**  
**17** 1-3 p.m. — Ancora Psychiatric Hospital, Hammonton  
**30** (*Ancora Psychiatric Hospital and AMNJ*)
- 2 Thyroid Disease**  
 11 a.m. — Greystone Park Psychiatric Hospital  
 (*AMNJ and AAFP*)
- 3 Lectures in Obstetrics/Gynecology**  
 6-10 p.m. — 141 S. Harrison St., E. Orange  
 (*New Jersey Medical School and AMNJ*)
- 3 Advances in Medicine**  
**10** 9:30-11 a.m. — Bergen Pines County Hospital  
**17** Paramus  
**24** (*Bergen Pines County Hospital and AMNJ*)
- 3 Cardiology Conferences**  
**17** 4-6 p.m. — Rutgers Medical School  
 (*CMDNJ and AMNJ*)
- 3 Medical Humanism-Hospital Ethics**  
 11:30 a.m. — Rahway Hospital  
 (*AMNJ and AAFP*)
- 3 Courses for Psychiatrists**  
 8-10 p.m. — Hackensack Hospital  
 (*NJ Psychoanalytic Society and AMNJ*)
- 4 Pediatric Allergy Course**  
**11** 11 a.m.-12 noon — Children's Hospital of Newark  
**18** (*Children's Hospital of Newark and AMNJ*)  
**25**
- 4 Infectious Diseases Course**  
 8:30-9:30 a.m. — Somerset Hospital, Somerville  
 (*Somerset Hospital of Newark and AMNJ*)
- 5 Cerebral Vascular Disease**  
 8:30 a.m. — United Hospitals of Newark  
 (*AMNJ and AAFP*)
- 6 MSNJ Annual Meeting**  
**9** Holiday Inn-Howard Johnson's Regency, Atlantic City
- 9 Fluid and Electrolyte Imbalance**  
 9 p.m. — Bayonne Hospital  
 (*AMNJ and AAFP*)
- 10 Arthritis**  
 1:30 p.m. — John E. Runnells Hospital, Berkeley Heights  
 (*AMNJ and AAFP*)
- 13 CME Program**  
**27** 8-10 a.m. — Newcomb Hospital, Vineland  
 (*University of Pennsylvania School of Medicine and AAFP*)

- 15 **Endotoxic/Hemorrhagic Shock**  
12 noon — Hospital Center at Orange  
(*AMNJ and AAFP*)
  - 16 **Kidney Stones**  
12 noon — St. Mary's Orange  
(*AMNJ and AAFP*)
  - 17 **Special Problems in Neurology**  
7-10 p.m. — VA Hospital, East Orange  
(*VA Hospital and AMNJ*)
  - 18 **Advances in Pediatrics**  
6:15 p.m. — Bridgeton Hospital  
(*Bridgeton Hospital*)
  - 18 **Antithrombotic Therapy**  
5-6:30 p.m. — Somerset Hospital, Somerville  
(*Somerset Hospital and AMNJ*)
  - 19 **Chronic Renal Failure**  
12 noon — Freehold Area Hospital  
(*AMNJ and AAFP*)
  - 23 **Common Topical Agents in Dermatological Practice**  
8:30-10 p.m. — 645 Cambridge Road, Paramus  
(*Bergen Co. Chapter, American Medical Women's Association and AMNJ*)
  - 23 **Cerebral Vascular Disease**  
8 p.m. — Warren Hospital, Phillipsburg  
(*AMNJ and AAFP*)
  - 26 **Ophthalmologic Manifestations in Systemic Disease**  
12:30 p.m. — Hamilton Hospital, Trenton  
(*AMNJ and AAFP*)
  - 31 **Cardiac Arrhythmias**  
3 p.m. — Ancora Psychiatric Hospital, Hammonton  
(*AMNJ and AAFP*)
- June
- 1 **Infectious Disease Course**  
8:30-9:30 a.m. — Somerset Hospital, Somerville  
(*Somerset Hospital and AAFP*)
  - 1 **Current Radiation Therapy**  
11 a.m. — Greystone Park Psychiatric Hospital  
(*AMNJ and AAFP*)
  - 2 **Lipid Metabolism**  
8:30 a.m. — United Hospitals of Newark  
(*AMNJ and AAFP*)
  - 5 **Neuroscience Conferences**  - 12 11:30 a.m.-12:30 p.m. — Bergen Pines County Hospital, Paramus
  - 19 Paramus
  - 26 (*Bergen Pines County Hospital and AMNJ*)
  - 5 **Thyroid Diseases**  
8 p.m. — Community Memorial Hospital, Toms River  
(*AMNJ and AAFP*)
  - 7 **Advances in Medicine**  - 14 9:30-11 a.m. — Bergen Pines County Hospital, Paramus
  - (*Bergen Pines County Hospital and AMNJ*)
  - 7 **Cardiology Conferences**  - 21 4-6 p.m. — Rutgers Medical School, Piscataway
  - (*CMDNJ and AMNJ*)
  - 7 **Psychiatry**  - 14 1-3 p.m. — Ancora Psychiatric Hospital, Hammonton
  - (*Ancora Psychiatric Hospital and AMNJ*)
  - 10 **Differential Diagnosis — the Wheezing Patient**
  - 24 **The Leukemias**  
8-10 a.m. — Newcomb Hospital, Vineland  
(*Newcomb Hospital and University of Pennsylvania Hospital*)
  - 15 **Beta-Adrenergic Blocking Agent in Cardiovascular Disease**  
5-6:30 p.m. — Somerset Hospital, Somerville  
(*Somerset Hospital and AMNJ*)
  - 16 **Sports Medicine**  
12 noon — Freehold Area Hospital  
(*AMNJ and AAFP*)
  - 20 **Northern Regional Chest Conferences**  
7:30-9:30 p.m. — Beth Israel Hospital, Newark  
(*New Jersey Thoracic Society and AMNJ*)
  - 20 **Acute and Chronic Leukemia**  
12 noon — St. Mary's Hospital, Orange  
(*AMNJ and AAFP*)

## 212th Annual Meeting

# May 6-9

*Headquarters Hotels*

**Holiday Inn — Howard Johnson's Regency**

## Atlantic City

See lodging reservation form — pg. 993, this issue



# OBITUARIES

## Dr. Martin J. Ackerhalt

Martin J. Ackerhalt, M.D., died on August 26, when the car he was driving crashed into the rear of a parked truck. Born in 1908 and educated at the Royal College of Physicians and Surgeons at Edinburgh, where he received his medical degree in 1938, Dr. Ackerhalt practiced general medicine and obstetrics in Clifton for many years. He was a charter Fellow of the American Academy of Family Practice and a member of the American Geriatrics Society. Dr. Ackerhalt also was a member of our Passaic County component and was on the staff at the Passaic Beth Israel Hospital.

## Dr. Eugene P. Caro

A member of our Union County component, Eugene Paul Caro, M.D., died on September 13. Born in 1918 in Brooklyn, New York and graduated from Long Island College of Medicine in 1943, Dr. Caro pursued a career in pediatrics in the Linden area. He was affiliated with St. Elizabeth and Elizabeth General Hospitals in that city and Rahway Hospital, and in the past also had served at St. Michael and Beth Israel Hospitals in Newark. Dr. Caro was a Fellow of the American Academy of Pediatrics. During World War II he served two years in the United States Army's medical department.

## Dr. Enrico Ciampi

Word has just been received of the untimely death, on August 27, at the age of 54, of Enrico Ciampi, M.D. Born in Italy, Dr. Ciampi was graduated from the medical school at the University of Palermo in 1955. He then emigrated to the United States, serving his internship in hospitals in New Jersey, and established a practice in general medicine in Newark. Dr. Ciampi was a member of our Essex County component, and was affiliated with Columbus, St. James, and St. Michael's Hospitals in Newark.

## Dr. Ralph A. Ford

Ralph Anthony Ford, M.D., medical director of the Essex County Geriatric Center in Belleville, died on September 13. Born in 1905 in Brockton, Massachusetts, Dr. Ford was graduated from Middlesex Medical School, Boston in 1929. He served his internship at the Essex County Hospital (now the Essex County Geriatric Center), was named senior resident physician in 1931, and in 1961 was appointed chief resident physician and medical director. Dr. Ford was a member of our Essex County component.

## Dr. Roy Griffith

At the venerable age of 88, Roy Griffith, M.D., from Essex County, died on August 10 in Mountainside Hospital in Glen Ridge. Born in McNutt, Georgia, Dr. Griffith was graduated from Johns Hopkins Medical School in 1915 and established a practice in orthopedic and traumatic surgery in Newark, later moving to Glen Ridge. Prior to his retirement in 1955, Dr. Griffith was affiliated with St. James Hospital in Newark and St. Barnabas Medical Center in Livingston. He held memberships in the Academy of Medicine of New Jersey, the Essex County Pathological and Anatomical Society, and the Physicians' Club of Essex County.

## Dr. George A. Hevesy

After a long illness, George Andrew Hevesy, M.D., a member of our Essex County component, died at his home on August 30. Dr. Hevesy was born in Budapest, Hungary in 1927, and was graduated from the Pazmany Peter University in that city in 1952. He emigrated to the United States in 1959 and served part of his internship at Orange Memorial Hospital, before establishing a practice in internal medicine in West Orange. Dr. Hevesy was affiliated with Orange Memorial Hospital, East Orange General Hospital, and St. Barnabas Medical Center in Livingston.

### **Dr. Emil E. Hornick**

Emil E. Hornick, M.D., a member of our Morris County component, died at his home in Mountain Lakes on August 31. Born in 1912 and graduated from Columbia University's College of Physicians and Surgeons, class of 1938, Dr. Hornick practiced obstetrics and gynecology in Morristown and Boonton until his recent illness. He was a Fellow of the American College of Obstetrics and Gynecology and had been on the attending staff at St. Clare's Hospital in Denville, at Riverside Hospital in Boonton, and at All Soul's and Morristown Memorial Hospitals in Morristown.

### **Dr. Francis J. McCauley**

One of Essex County's senior members, Francis J. McCauley, M.D., died on August 28 at the grand age of 86. Dr. McCauley was graduated from Jefferson Medical College, class of 1916, and spent the next three years serving in the medical corps of the United States Navy during World War I. He pursued graduate studies in dermatology at Vanderbilt Clinic and New York University-Bellevue Hospital, before establishing a practice in dermatology and syphilology in Newark. Dr. McCauley was on the staff at Martland and Children's Hospitals and the Eye and Ear Infirmary in Newark, as well as St. Barnabas Medical Center at Livingston. He had served also as a consultant at St. Clare's Hospital in Denville, Clara Maass Memorial Hospital in Belleville, Irvington General Hospital, and Presbyterian and American Legion Hospitals in Newark. He was a Fellow of the American Academy of Dermatology, a diplomate of the American Board of Dermatology, a member of the New Jersey Dermatological Society, holding office as president in 1936, and a member of the Academy of Medicine of New Jersey.

### **Dr. Sol M. Papperman**

After a lengthy illness with Parkinson's disease, Sol M. Papperman, M.D., died on September 11. Dr. Papperman was born in New York City in 1918 and graduated from Tulane University

Medical School in 1955. He established a practice in internal medicine and gastroenterology in Lodi, becoming a member of our Bergen County component. Dr. Papperman was affiliated with Fair Lawn Memorial Hospital in that city and Valley Hospital in Ridgewood. During World War II he served as a captain for five years in the medical corps of the Army of the United States. Dr. Papperman was a Fellow of the Academy of Medicine of New Jersey, and a diplomate of the National Board of Medical Examiners.

### **Dr. Ettore G. Rizzo**

One of Passaic County's senior members, Ettore G. Rizzo, M.D., died at his home in Old Bridge after a long illness. Born in 1903 and graduated from the University of Naples Medical College in 1933, Dr. Rizzo pursued graduate training in pediatrics at New York Foundling Hospital, the University of Naples, and New York Medical College and practiced general medicine in Paterson until 1962, when he accepted appointment as a full-time member of the staff at Marlboro Psychiatric Hospital. Disability forced his retirement in 1969. Dr. Rizzo had been affiliated with Preakness Hospital in Wayne and was a school physician in Paterson for many years. During World War II, Dr. Rizzo served four years with the medical department of the Army of the United States, earning a bronze star during operations in the European theater.

### **Dr. Saul Siegendorf**

At the untimely age of 58, one of Passaic County's well known urologists, Saul Siegendorf, M.D., died on August 25 at Passaic General Hospital, where he had been a member of the staff for many years. A graduate of Tulane University School of Medicine, class of 1945, Dr. Siegendorf served residencies in urology at New York Medical College, New Orleans Veterans Administration, and Lincoln Hospital in New York City. In addition to his affiliation with Passaic General, where he had been chief of the department of urology, he was senior attending in urology at Passaic Beth Israel Hospital.

# BOOK REVIEWS

**Handbook of Obstetrics and Gynecology.** Sixth Edition.  
Ralph C. Benson, M.D. Los Altos, California, Lange, 1977.  
Illustrated. Pp. 772. (\$9.50)

Once again Professor Benson is offering the "medical student, nurse practitioner, midwife, and the busy physician" another edition of his somewhat abbreviated textbook disguised as a handbook. Some of the errors from the fifth edition are repeated and a few controversial items are added. Decreased milk intake for the prevention of leg cramps, oral progestogens for threatened abortion, diuretics for pre-eclampsia, sequential oral contraceptives, and the Dalkon Shields are subjects worthy of discussion among experienced obstetricians and gynecologists but definitely not for the readers of a handbook. Too much space is devoted to operative obstetrics, gynecologic surgery, and psychosomatic and sexual problems.

Although the vast majority of the material in these last two editions of the *Handbook* is well written, well illustrated, and well printed, the presence of a few controversial items presented as accepted doctrine, as well as typographical and orthographical errors cast doubt upon the validity of the rest of the subject matter. It is earnestly hoped that forthcoming editions will be reviewed and edited more assiduously because a medical author assumes a much greater responsibility toward his readers and ultimately for their patients than a novelist or journalist, particularly when his publisher is selling American medical science to developing countries. The need still exists for a concise, accurate, well-edited handbook, and this is not it.

Jerome Abrams, M.D.

**Medical Records.** Bernard Benjamin, Editor. London, William Heinemann Medical Books, 1977. Pp 235 (\$6.50)

This book is a first effort, under the editorship of Dr. Benjamin, of a number of members of the British Association of Medical Records' officers. It is very interesting to me after having observed the National Health Service because it gives a good deal of insight into the British system. The authors are quite candid in places.

The general practitioners' records are described in detail and very accurately. That the authors disapprove of them is quite clear:

"General practice records must improve or many of the opportunities for better management of the Health Service, so painfully provided by its organization, will remain tantalizingly out of reach."

The book's eighteen chapters are quite thorough and cover all aspects of modern medical record-keeping, except medical audit, utilization review, quality control of health services, and those aspects of peer review which now are commonplace.

This book might be of interest to a hospital medical records' librarian, but I doubt that she could apply much of its contents to our system.  
Arthur Krosnick, M.D.

**General Ophthalmology.** 8th Edition. Daniel Vaughan, M.D. and Taylor Asbury, M.D. Los Altos, California, Lange, 1977. Illustrated. Pp. 379. (\$12)

By coincidence I was asked by *The Journal*, MSNJ, to review the sixth edition of *General Ophthalmology* in 1971. I find that in comparing the two texts, the latest edition is some 60 pages larger and shows the effort of careful updating throughout.

I had found the earlier edition very complete and informative to medical students, general physicians, and beginning ophthalmology residents alike. This new revision can be equally recommended. I am very much impressed by the rewriting of the section on fluorescein angiography, one of the exciting new diagnostic modalities in present-day ophthalmology. In a concise description, the entire technique, equipment and materials and normal and abnormal findings are described accurately.

The important chapter on the retina is entirely rewritten, bringing up to date the current concepts of pathophysiology of macular and peripheral retinal disease. Diabetic retinopathy, the leading medical cause of blindness in the United States today, was not even mentioned in the sixth edition. In the present edition it occupies two full pages with descriptions of clinical findings and treatment.

Medical knowledge is advancing so rapidly today that books may become obsolete as soon as they are published. I would like to commend the authors of *General Ophthalmology* for performing the difficult task of keeping their excellent textbook a source of basic ophthalmologic knowledge, while including lucidly explained topics of current interest.

Arthur S. Kern, M.D.

**Review of Physiological Chemistry.** 16th Edition. H. A. Harper, V. W. Rodwell, P. A. Mayes. Los Altos, California, Lange, 1977. Pp. 681. (\$13)

The 16th edition of the *Review* represents a reorganized and substantially enlarged version of what is by now an almost classic series of biochemical compendia. Several new chapters have been added and previous deficiencies (such as inadequate coverage of newer aspects of molecular biology) largely have been rectified. The *Review* includes a number of new summary figures which effectively summarize recent information in a number of areas. The *Review* also has been supplemented with additional discussions of the relevance of biochemistry to disease. The authors have integrated a systemic concept or "whole organ" approach to biochemistry while giving adequate attention to recent discoveries at the molecular level.

While the *Review* is suitable for those readers seeking to gain introduction to the subject, it appears particularly useful for those reviewing in preparation for state and specialty board examinations.  
Richard A. Harvey, M.D.



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**Adverse Reactions:** Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at

the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

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**Usage in Pregnancy:** Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

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*R. M. Abel, M.D., et al.*

Subcutaneous Mastectomy

*R. M. Goldwyn, M.D.*

Acute Myocardial Infarction  
Among Blacks

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**WARNING:** Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns covering more than 20 percent of the body surface is

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Complete literature available on request from Professional Services Dept. PML.

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## New Double-Blind Study ANDROID-25 vs. Placebo\*

\* **WRITE FOR REPRINT:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioğlu, M.D.: Hormones for Improved Sexuality in the Male and Female Climacteric. *Drug Therapy*, Sept. 1976.

Is there a true aphrodisiac? How effective are androgens in the management of the male climacteric and male impotence? Article discusses the psychophysiological and hormonal changes in the elderly male and female and therapeutic considerations. The effectiveness of methyltestosterone in the management of male impotence was confirmed by a cross-over, double-blind study using a placebo and Android-25

(methyltestosterone 25 mg.), on 20 males, 50 years of age or older who complained of secondary impotence. Patients received a series of placebo then Android-25, or Android-25 then placebo as follows: 1 tablet/30 days; 2 tablets/30 days; 3 tablets/30 days. Sexual response was evaluated: 0 = no change, + = 25% improvement, ++ = 50% improvement, +++ = 75% improvement. Placebo effectiveness was + or ++ in 12.7% of trials. Android-25 elicited a +, ++ or +++ response in 47.2% of trials. There was often a dose related response not observed with the placebo. This effect was not observed in younger patients (age 28-45 years).

**DESCRIPTION:** Methyltestosterone is 17 $\beta$ -Hydroxy-17-Methylandro-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-pubertal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

**REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. In the male: Eunuchoidism and eunichism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpubertal cryptorchidism, 30 mg. **REFERENCE:** Robert B. Greenblatt, M.D., and D. H. Perez, M.D.: "The Menopausal Syndrome," *Problems of Libido in the Elderly*, pp. 95-101. Medcom Press, N.Y., 1974. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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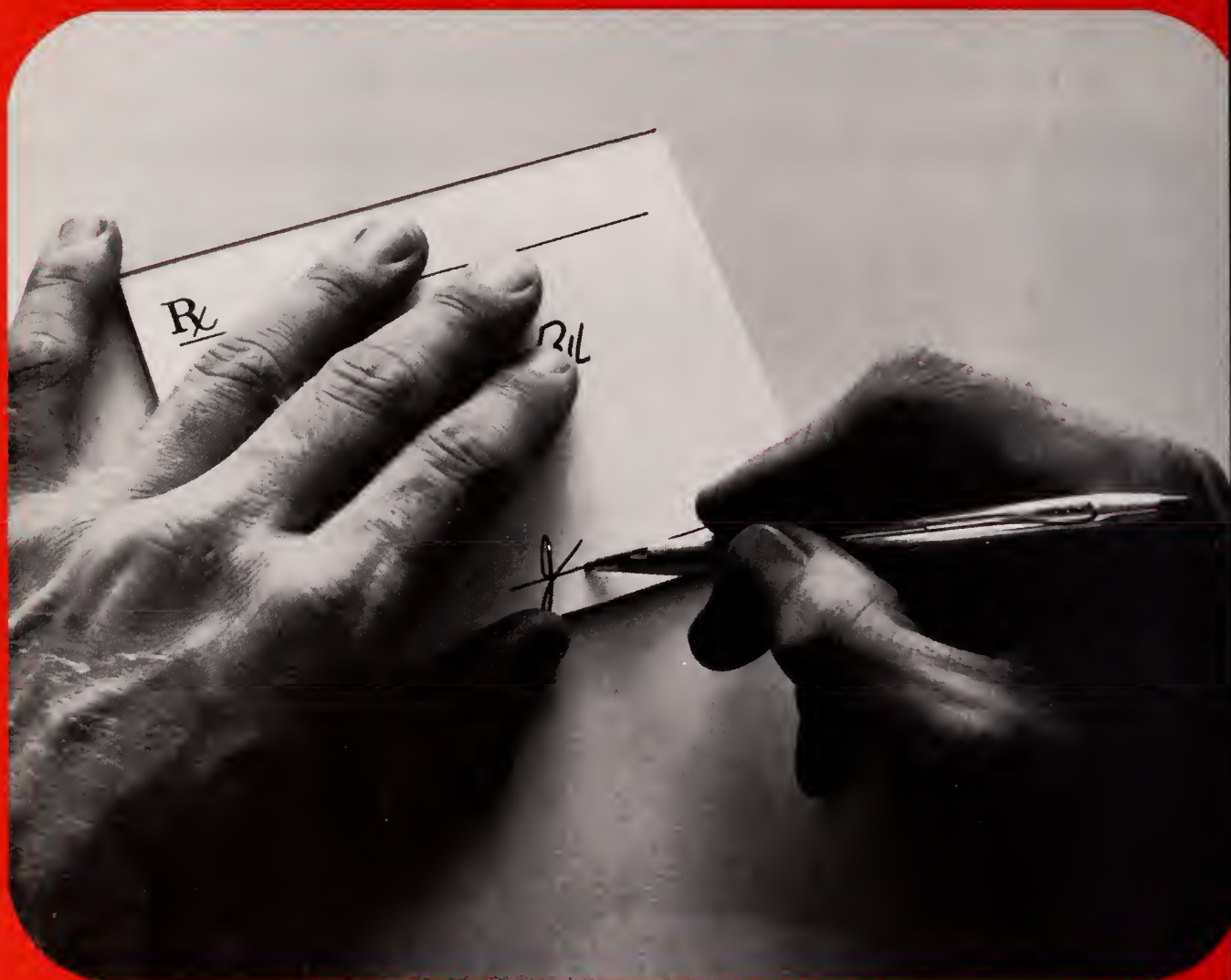
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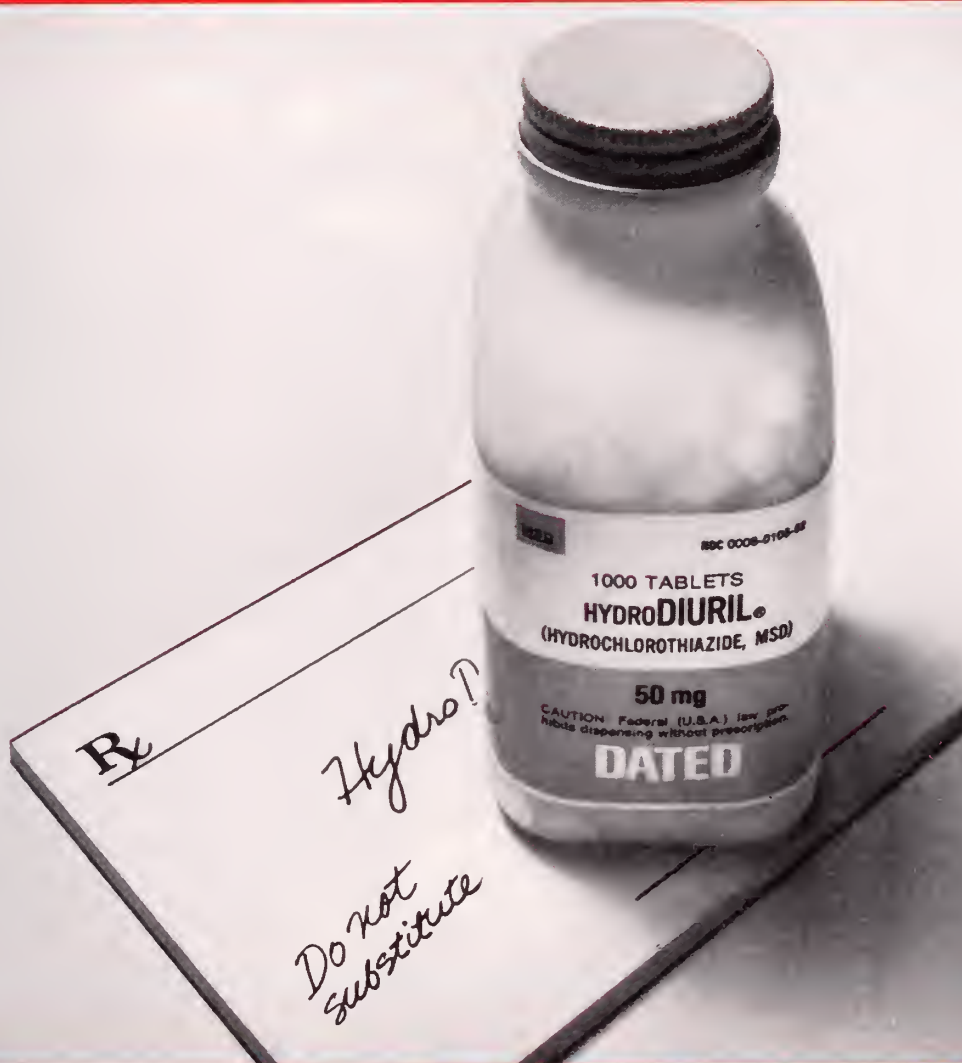
**Contraindications:** Anuria, hypersensitivity to this or other sulfonamide-derived drugs.

**Warnings:** Use with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. Cumulative effects may develop in patients with impaired renal function. Use with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma. May add to or potentiate action of other antihypertensive drugs; potentiation occurs with ganglionic or peripheral adrenergic blocking drugs. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possibility of exacerbation or activation of systemic lupus erythematosus has been reported. Lithium generally should not be given with diuretics because they reduce its renal clearance and add a high risk of lithium toxicity. Read circulars for lithium preparations before use of such concomitant therapy. **Use in Pregnancy:** Thiazides cross placental barrier and appear in cord blood; in pregnancy, weigh anticipated benefit against possible hazards to fetus, including fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions that have occurred in adults. **Nursing Mothers:** Thiazides appear in breast milk; if use of drug is deemed essential, patient should stop nursing.

**Precautions:** Perform periodic determination of serum electrolytes to detect possible electrolyte imbalance. Observe all patients for clinical signs of fluid or electrolyte imbalance, namely, hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when patient is vomiting ex-

cessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs, irrespective of cause, are dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting. Hypokalemia may develop, especially with brisk diuresis in severe cirrhosis, with concomitant corticosteroid or ACTH therapy, or with inadequate oral electrolyte intake. Hypokalemia can sensitize or exaggerate response of heart to toxic effects of digitalis (e.g., increased ventricular irritability). Hypokalemia may be avoided or treated by use of potassium supplements, such as foods with a high potassium content. Any chloride deficit is generally mild and usually does not require specific treatment except under extraordinary circumstances (as in liver disease or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt except in rare instances when the hyponatremia is life threatening. In actual salt depletion, appropriate replacement is the therapy of choice. Hyperuricemia may occur or frank gout may be precipitated in certain patients. Insulin requirements in diabetic patients may be increased, decreased, or unchanged; latent diabetes mellitus may become manifest. Thiazides may increase responsiveness to tubocurarine. Antihypertensive effects of the drug may be enhanced in post-sympathectomy patients. May decrease arterial responsiveness to norepinephrine; this diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use. If progressive renal im-

# for experience—



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airment becomes evident, consider withholding or discontinuing diuretic therapy. Thiazides may decrease serum PBI levels without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. Pathologic changes in the parathyroid gland with hypercalcemia and hypophosphatemia have been observed in a few patients on prolonged therapy; thiazides should be discontinued before testing for parathyroid function.

**Adverse Reactions:** *Gastrointestinal System*—Anorexia; gastric irritation; nausea; vomiting; cramping; diarrhea, constipation; jaundice (intrahepatic cholestatic jaundice); pancreatitis; sialadenitis.

*Central Nervous System*—Dizziness; vertigo; paresthesias; headache; anopsia.

*Hematologic*—Leukopenia; agranulocytosis; thrombocytopenia; aplastic anemia.

*Cardiovascular*—Orthostatic hypotension (may be aggravated by alcohol, barbiturates, or narcotics).

*Hypersensitivity*—Purpura; photosensitivity; rash; urticaria, necrotizing angitis (vasculitis) (cutaneous vasculitis); fever; respiratory distress including pneumonitis; anaphylactic reactions.

*Other*—Hyperglycemia; glycosuria, hyperuricemia; muscle spasm; weakness; restlessness; transient blurred vision.

Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn.

**Note:** When used with other antihypertensive drugs, careful observations for changes in blood pressure must be made, especially during initial therapy. Dosage of other antihypertensive agents must be

reduced by at least 50 percent as soon as this drug is added to the regimen. As blood pressure falls under the potentiating effect of this agent, further reduction in dosage, or even discontinuation, of other antihypertensive drugs may be necessary.

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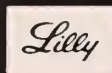
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## EDITORIALS

### Harrold A. Murray, M.D. 1893-1977

Doctor Harrold A. Murray, 160th President of the Medical Society of New Jersey (1952-1953), died on Friday, October 14. At the time of his death he was residing in Sea Girt, but his life-long activities centered about his native city, Newark, where his funeral mass was offered in the Church of Our Lady of Good Counsel on October 17.

Doctor Murray attended Barringer High School and Seton Hall University, which awarded him baccalaureate and masters degrees in arts and subsequently (1952) conferred upon him the degree of Doctor of Laws, "honoris causa." His medical degree was granted by the College of Physicians and Surgeons of Columbia University in 1920. Young Doctor Murray interned at Newark City Hospital and then pursued thirteen years of postgraduate work in pediatrics at Mount Sinai Hospital, New York City, in association with the famous Dr. Bela Schick, who, in 1957, acclaimed him as "Newark's Prince of Pediatrics."

Among the first to recognize pediatrics as a form of sociology, as well as a form of medicine, Doctor Murray was a diplomate of the American Board of Pediatrics, a Fellow and past-District Chairman of the American Academy of Pediatrics, a Fellow of the American College of Physicians, a Trustee of the Academy of Medicine of New Jersey, and Director of Pediatrics at St. Michael's Medical Center and at St. James and Newark City Hospitals. He was a past-president of the Essex County Medical Society, a member of the Governor's Committee on Youth, president of the New Jersey Child Caring Group, and a member of the Boards of Trustees of the New Jersey Welfare Council and the New Jersey Heart Association.

His wife was the former Beatrice Sanders of Newark, who predeceased him. Doctor Murray is survived by three sons—Very Reverend Monsignor Harrold A., John, and Michael, and by two daughters—Mrs. Beatrice Farley and Mrs. Sara Grantham.

"Dynamic" was the word for Harrold Murray, in everything from his widely ranging interests to his zest for living and for people. Keen of mind, enthusiastic in his energies, he embodied and exemplified those attributes indispensable for accomplishment.

Richard I. Nevin

### Season's Greetings

The editorial and business staffs of *The Journal* offer season's greetings and wish the best, the happiest, and the healthiest New Year to our readers.

Let us hope that the elected custodians of the government of our great nation will have the good sense to keep their eyes on our economy, their noses to the grindstone, and their gluteus muscles on the saddle, instead of playing football with the health system of America.

Let us resolve, for the New Year, to remain strong proponents of what is right and adversaries of what is wrong for our patients. Let us be mindful of the economic limitations of our patients, while providing unlimited care and diligence to their health needs.

"The ultimate strength of a controller (government) depends upon the strength of those whom he (it) controls. The wealth of a rich man depends upon the productivity of those whom he controls through wealth; slavery as a technique in the control of labor eventually proves nonproductive and too costly to survive. The strength of a government depends upon the inventiveness and productivity of its citizens; coercive controls which lead to inefficient or neurotic behavior defeat their own purpose. An agency which employs the stupefying practices of propaganda suffers from the ignorance and the restricted repertoires of those whom it controls. A culture which is content with the status quo—which claims to know what controlling practices are best and therefore does not experiment—may achieve a temporary stability but only at the price of eventual extinction."

B.F. Skinner

As an honorable profession, let us resolve to remain strong, inventive, productive, stable, and united.

A.K.

## The Myth of the Free Lunch

In the first third of this century there existed a phenomenon with which most of us in the middle years or older are familiar. It was called the "free lunch" and it was obtained in the neighborhood saloon. Characteristically, the working man stopped in at the corner bar for a glass, mug, or pitcher of beer (depending on the size of his thirst) at the noon hour and to partake of the comestibles which were close at hand at the end of the bar. The assortment of hard-boiled eggs, pieces of herring, sliced meat, and other delicacies resembled nothing less than a delightful smorgasbord (according to a distant mental image). Although the beer was cheap by today's standards the lunch was cheaper—it was free! But was it really free?

If one gives a little thought to the situation, the combination of beer and free edibles has a strange resemblance to today's free school lunch program, the food stamp program, aid to unwed mothers, and very likely to the national health insurance programs of the future. Government representatives would like the voters to believe that the "free lunch" does exist and perhaps it does for some of the recipients of such aid. The following quotation\* concisely summarizes the fallacy of this fable, however:

"A natural part of human nature, it seems, is the unquenchable desire to get something for nothing. The fact that you don't pay for a lunch doesn't make it free. Somebody picks up the tab—and that's why government handouts are as spurious as free lunches. Government is *never* a source of material goods. Everything pro-

duced is produced by the people. Everything the government gives to people it first must take from them. The only money the government has to spend is that taxed or borrowed out of the people's earnings. When government decides to spend more than it gets in this way, the extra unearned money must be created out of thin air *via* the printing press. This devaluation is called inflation and it's the tab we all pick up when we allow government to sell us the myth of the 'free lunch.' "

In the old days, the price of the beer was enough to pay for the "free lunch," the sodium content of which was high enough to assure a grand thirst and a large consumption of the brew of the hops. Nevertheless, the barkeeper and the customer both ended up happy; the former made a nice profit and the latter had a full stomach and his "free lunch."

National health insurance never will be a "free lunch," in fact, some predict its recipients may find it unpalatable—both to the stomach and to the pocketbook. That it will be expensive one can have no doubt. That it will serve the needs of our patients one can have grave doubts.

If free health care is part of that "unquenchable desire to get something for nothing," American Medicine has a big job cut out for it. The "free lunch" of the saloon of the 20's and 30's is gone without a trace. The present government's concept of the "free (health care) lunch," if enacted, may stick in the craw of the American public forever.

A. K.

\*"Why There's No Such Thing As a Free Lunch." *Success Unlimited*. Chicago, July 1977. Republished courtesy of AMWAY Corporation.

### Cover Photo

The cover photo, "Town of Rancocas—Winter 1976" was provided by John L. Krause, Jr., M.D., plastic surgeon, Cherry Hill, a member of our Camden County Medical Society. Dr. Krause is an accomplished medical and nature photographer, as well as a lecturer on these subjects.

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## Intra-Aortic Balloon Counterpulsation in Community Hospital\*

Interface with Open-Heart Centers and  
Description of a Patient Transport System

**Ronald M. Abel, M.D.,  
V. A. Subramanian, M.D.,  
J. C. McCabe, M.D., and  
William A. Gay, Jr., M.D., New York**

The mortality rate for severe cardiogenic shock following acute myocardial infarction remains exceedingly high, particularly in patients refractory to augmentation of left ventricular filling pressure utilizing pulmonary arterial wedge pressure monitoring and failure of an early response to cardiac pressor agents.<sup>1,2,3,4</sup> The use of intra-aortic balloon pumping (IABP) in patients with cardiogenic shock alone<sup>5,6,7</sup> and in patients with acute papillary muscle rupture, ventricular septal perforation, refractory ventricular arrhythmias, or persistent ischemia<sup>8,9,10</sup> has been shown to bring about an immediate hemodynamic improvement in a majority of such patients. The role of IABP alone is limited, however, in that temporary circulatory support by this method is responsible for only a small percentage of long-term survivors who become hemodynamically stable independent of counterpulsation.<sup>11,12</sup> The overwhelming majority of patients placed on IABP counterpulsation remain dependent on this circulatory support, and, therefore, early coronary angiography and left ventriculography followed by palliative cardiac surgery becomes the only hope for patient survival.<sup>11,12</sup> Employing this aggressive approach in "Class IV" cardiogenic shock in patients who heretofore were faced with a 100 percent mortality rate resulted in acute patient survival rates as

high as 37 percent and late survival (one to three years) of 29 percent.<sup>8</sup>

The institution of such a program requires demanding, time-consuming, heroic efforts by a large, multidisciplinary team in a large medical center capable not only of managing patients requiring IABP, but with cardiac catheterization laboratory and open-heart surgical facilities. Because of the economic and personnel limitations implicit in the magnitude of such a program, the community hospital obviously has been limited in its capacity to deliver this type of care.

For these reasons, a pilot project was initiated in 1973 at the Salem Hospital, Salem, Massachusetts, a 360-bed community hospital forty minutes away from the Massachusetts General Hospital in Boston, where an active IABP program had been established several years earlier.<sup>13</sup> With the use of a patient transport vehicle modified to carry a patient safely during uninterrupted IABP, six patients of the first sixteen IABP patients at the Salem Hospital were transferred for open-heart surgery; four of them survived. The program has now expanded in the greater Boston area to include at least three additional community hospitals,

\*From the Department of Cardiothoracic Surgery, New York Hospital—Cornell Medical Center. This paper was read before the joint Sections on Cardiovascular Diseases, Family Practice, and Medicine, 211th Annual Meeting, the Medical Society of New Jersey, May 15, 1977, Atlantic City. Reprints may be requested of Dr. Abel at 525 East 68th Street, New York 10021.

three open-heart centers, and four ambulance companies capable of managing this type of patient transport.

The following report describes the institution of a similar program in the metropolitan New York City area which was instituted in November, 1975, and the logistics involved with successful IABP and transport of the first two patients in this program.

#### Procedures at The New York Hospital-Cornell Medical Center

Counterpulsation is managed with the Avco bidirectional intra-aortic balloon pump system. Balloon pump catheters generally are inserted under local anesthesia either in the surgical intensive care unit under emergency conditions, or in the operating room if time and hemodynamic status of the patient permit. The procedure (usually performed by the senior surgical house staff) consists of wide exposure of the proximal common femoral artery (Figure 1). Following intravenous injection of 7500 units of heparin, a vertical arteriotomy is performed as high in the common femoral artery as possible. (Figure 2). A balloon pump catheter of appropriate size (20, 30, or 40 ml. capacity) is gently inserted (Figure 3) into the aorta so that the tip is just below the left subclavian artery, as judged by appearance on plain antero-posterior chest roentgenogram or fluoroscopy. (Figure 4). The catheter is fixed by an end-to-side anastomosis to the common femoral artery with a 10 to 12 mm. woven Dacron® or Teflon® vascular graft through which the catheter passes; this maintains flow through the lower extremity.

Following a period of hemodynamic stability and independence from IABP support, the pump catheters are removed under local anesthesia by re-opening the incision, passing balloon-tipped embolectomy catheters proximally and distally (Figure 5) to assure the absence of thrombotic material, and the excess graft material trimmed away. The technical management of intra-aortic balloon pumping in these patients is by the cardiothoracic surgical house staff and by the surgical intensive care unit nurses, who have undergone a

program of training within The New York Hospital.†

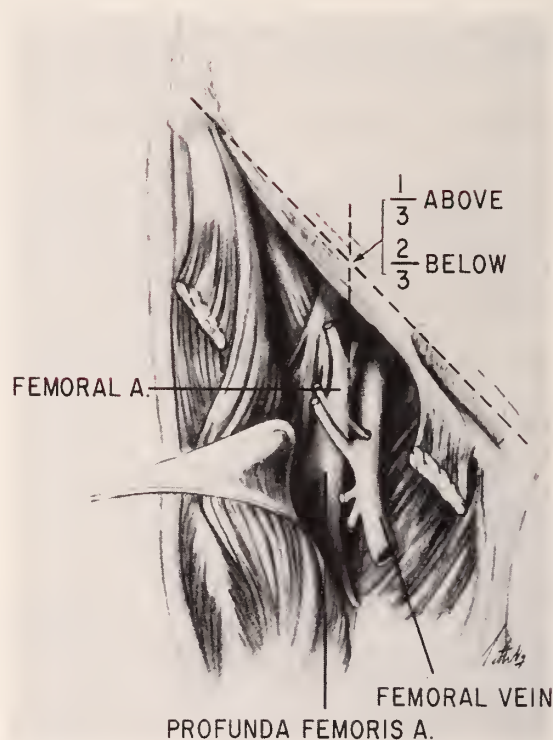


Figure 1—Surgical anatomy of the common femoral vessels during intra-aortic balloon pumping catheter insertion. A high vertical incision should be made directly over the common femoral artery to assure as proximal location in the vessel as possible of the balloon pump catheter.

#### Ambulance Transport Team

Patients in cardiogenic shock are transported to The New York Hospital by a team of paramedics trained in cardiopulmonary resuscitation techniques. The paramedics, who also have attended basic courses in intra-aortic balloon pumping†, remain in constant radio contact with the hospital during patient transfer and convey electrocardiographic tracings telemetrically to the hospital. A senior attending surgeon and surgical resident also may proceed out with the paramedic team if necessary.

#### Transport Vehicle

The vehicle presently utilized is a 27-foot mobile home with a rear door converted with a fold-up

†Kindly provided by Mr. Jerry Cicciu, Avco Medical Products, Everett, Massachusetts.



ramp and electric winch, Hewlett-Packard monitoring equipment consisting of three pressure transducers and electrocardiogram, 7.5 KW generator for AC power, a sink with hot and cold water, ample room for a full-sized hospital bed, volume-regulated respirator, defibrillator, air conditioner, two independent heating units, two-way radio, and a refrigerator, in addition to the standard resuscitation equipment and drugs.



Figure 2—Location of the vertical arteriotomy in the proximal common femoral artery.

### Community Hospital Procedures

In community hospitals with current balloon-pumping capacity, suitable patients (Case #1) are placed on IABP and transported when stable and deemed to be acceptable for further study and treatment. These patients then are transported on a semi-elective time schedule, since hemodynamic stability already has been obtained at the primary hospital.

In the hospital setting in which IABP is not presently available (Case #2) and the patient is deemed too unstable to transport by conventional ambulance, the IABP team, with the equipment required for emergency IABP insertion, proceeds to the community hospital

emergency ward or coronary care unit. Although far less desirable, this type of arrangement is considered feasible in certain instances in which circulatory support is absolutely required in order to achieve safe patient transport.

The following two case reports summarize the first such patients transported successfully during uninterrupted IABP by both of the methods described. The results of the entire pilot study also are presented.

### Case Reports

**Case #1**—A fifty-four year old man developed acute anterior chest pain radiating to both arms while attempting to climb a hill. On admission to a community hospital a diagnosis of acute diaphragmatic myocardial infarction was made and supportive measures were instituted. Within twelve hours the patient became oliguric and hypotensive and required intravenous infusions of fluid, norepinephrine, and dopamine in moderate to high doses. Within another twelve hours, however, progressive oliguria, disorientation, arterial hypotension in the range of 60mm. Hg. developed despite large doses of catecholamines, therefore an intra-aortic balloon pump was inserted and counterpulsation initiated. Although the patient's mean blood pressure stabilized at 100mm. Hg, he became anuric and mentally obtunded with cold and clammy extremities.

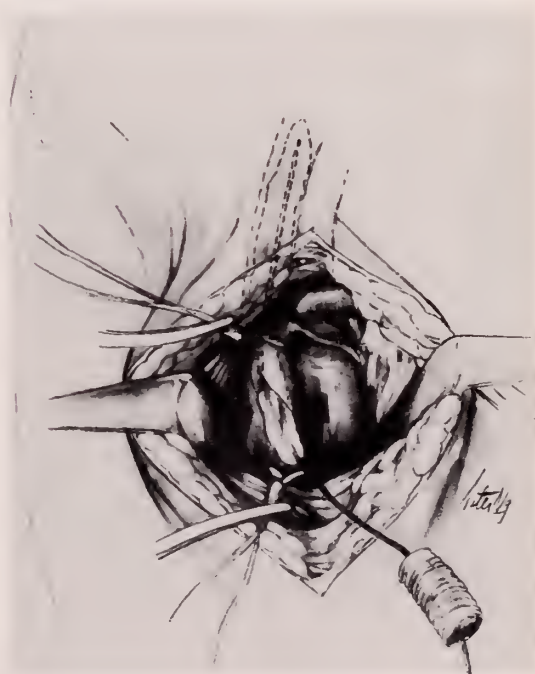
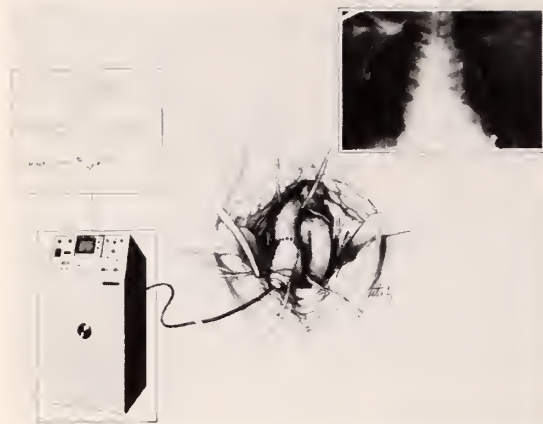


Figure 3—Passage of the deflated balloon pump catheter into the common femoral artery through a 10mm. woven dacron vascular prosthesis.



**Figure 4**—Completed anastomosis of the dacron prosthesis to the common femoral artery. The insets show proper location of the tip of the balloon pump catheter (upper right) hemodynamic consequences of institution of balloon pumping on peripheral arterial pressure and pulmonary artery wedge pressure (upper left), and the balloon pump console utilized (lower left).

After consultation with members of the cardiothoracic service at The New York Hospital, it was elected to transfer the patient by means of the "Intensive Heart Care Module" for coronary arteriography and possible surgical intervention. Just prior to transfer, however, abdominal distension with diffuse tenderness and bloody diarrhea were noted.

During transport, the patient was carefully monitored by continuous intra-arterial blood pressure recordings and supportive therapy was maintained by the paramedic squad. Balloon counterpulsation was uninterrupted between the two institutions.

On admission to The New York Hospital a blood pressure of 90-100 mm. Hg., mean pulmonary capillary wedge pressure of 14-18 mm. Hg., and normal sinus rhythm were noted. Abdominal examination revealed absent bowel sounds with rebound tenderness. There was gross blood in the nasogastric tube aspirate and bloody diarrhea persisted. Chest x-ray revealed dilated small bowel loops with no free intraperitoneal air. Because of progressive respiratory insufficiency, endotracheal intubation and ventilatory support were instituted. Cardiac output (thermodilution technique) was 3.2 l/min.

Following a brief period of stabilization during which time a lower dosage of norepinephrine plus an intravenous infusion of nitroprusside were initiated, the patient was taken to the cardiac catheterization laboratory. Coronary angiography revealed a 95 percent stenosis of the mid-portion of the right coronary artery with good distal antegrade filling of a dominant vessel. The left coronary artery was unremarkable and left ventriculography revealed akinesis of the diaphragmatic left ventricular wall.

He was taken to the operating room on the evening following admission with a preoperative diagnosis of massive diaphragmatic myocardial infarction with cardiogenic shock and presumed mesenteric vascular occlusion with bowel infarction. A single aorto-coronary saphenous vein bypass graft was performed to the distal right coronary

artery. Following reversal of systemic heparinization and closure of the chest, a laparotomy was performed. Sixty centimeters of the terminal ileum were found to be necrotic and were resected with a primary end-to-end anastomosis. The sigmoid colon also was necrotic for a distance of approximately six centimeters and was resected with an end colostomy and a distal mucus fistula brought through the skin.

Postoperatively, he remained in acute anuric renal failure and required intermittent hemodialysis via an arterio-venous shunt. The intra-aortic balloon pump was removed in 72 hours because of hemodynamic stability requiring no additional inotropic support. Because of a continued obtunded state and respiratory failure, a tracheostomy was performed; the patient required ventilatory support for approximately three weeks. Total parenteral nutrition was initiated shortly after admission and was continued for five weeks using a solution of essential l-amino acids and hypertonic dextrose.<sup>14, 15, 16</sup> He was discharged from the hospital eight weeks following admission, but required dialysis thrice weekly and a Giordano-Giovanetti diet. Within two weeks following his return home, daily urinary volumes increased



**Figure 5**—Technique of balloon pump catheter removal. Using distal local occlusion of the common femoral and profunda femoris arteries, the catheter is removed and a large amount of blood is allowed to purge through the graft (upper panel). Using local occlusion of the distal vessels a balloon-tipped embolectomy catheter is first passed proximally (middle panel), and then distally to remove thrombotic material. Finally, (lower right panel), excess graft is trimmed away and the prosthesis is over-sewn with a single running vascular suture.



and by three weeks following discharge, dialysis was no longer necessary.

Six months following his initial admission the patient was readmitted to the hospital for an uneventful colostomy closure and repeat cardiac catheterization. The coronary bypass graft was patent and motion of the diaphragmatic left ventricular wall was markedly improved, compared with the preoperative study. The patient has regained normal renal function and has returned to full employment.

**Case #2**—A forty-five year old man entered a community hospital on February 5, 1976 with a five-day history of progressively severe chest pain followed by cardiovascular collapse. The patient was severely obtunded with a palpable arterial blood pressure of 40 mm. Hg. General supportive measures including volume infusion and catecholamine therapy failed to improve his blood pressure or relieve his metabolic acidosis. One hour after admission a telephone consultation with the cardio-thoracic team at The New York Hospital was made and it was elected to proceed out with a team of paramedics and cardiovascular surgeons via the "Intensive Heart Care Module" to institute intra-aortic balloon counterpulsation. This was performed uneventfully, within two hours, under local anesthesia in the community hospital emergency room. Following a brief period of stabilization, during which time the dose of norepinephrine was significantly diminished, the patient underwent an uneventful transport to The New York Hospital. When taken to the catheterization laboratory, his systolic arterial blood pressure was 100 mm. Hg., with continuous intravenous norepinephrine infusion. Selective coronary arteriography revealed a 90 percent obstruction in the middle third of a strongly dominant right coronary artery with a distal artery free of significant disease. The left anterior descending coronary artery was totally obstructed in its mid-portion and the distal vessel was never visualized. A thin, irregular circumflex coronary artery was quite small and severely diseased. Left ventriculogram revealed marked hypokinesia of the posterior and diaphragmatic walls with hypokinesia of the remaining ventricle. The left ventricular end-diastolic pressure was 22 mm. Hg. and a cardiac index was 2.57 l/min/M<sup>2</sup>. Over the next six hours peritoneal dialysis to correct severe hyperkalemia due to his acute, anuric renal failure, and correction of severe diabetic keto-acidosis were instituted. He acquired a reasonable metabolic balance by the time he was taken to the operating room sixteen hours after admission.

During induction of anesthesia the patient suddenly became markedly hypotensive and developed electromechanical dissociation. A median sternotomy was rapidly performed and it was apparent that he had developed left ventricular rupture with pericardial tamponade. Cardiopulmonary bypass was instituted and the patient cooled to 22°C. In the diaphragmatic wall, there was a large ventricular rupture which consisted of several one centimeter perforations through severely necrotic and friable tissues. This area of rupture was sutured and a bypass graft placed to the distal right coronary artery. The patient could not be weaned from cardiopulmonary bypass because of severe left ventricular failure and died in the operating room.

### Summary of Overall Patient Transport Statistics

During this early phase of the pilot study initiated at our institution, there have been

transported during uninterrupted intra-aortic balloon counterpulsation fourteen patients from eight community hospitals, in the period from January 23, 1976 through March 6, 1977. Two additional cases were similar to Case #2 in that the balloon pump was instituted on arrival by the proceed-out team, namely, inserted quite late during the course of profound cardiogenic shock. All three of these patients eventually succumbed. It is our current recommendation that the institution of intra-aortic balloon counterpulsation at this late period probably will result in too low a patient salvage to make this aspect of the program a reasonable one to pursue in the future. Any institution that predicts a significantly large enough patient population so as to require balloon counterpulsation, therefore, actively should seek to acquire the facilities for in-house management of balloon counterpulsation so that its institution can occur prior to secondary organ system failure such as cerebral vascular accidents, acute renal failure, and hepatic necrosis.

Of the remaining eleven patients who were balloon pumped at the community hospital and, when stable, were transported to our institution, a total of six (43 percent) survived the palliative cardiac surgical procedure and were at least short-term survivors of cardiac surgical intervention. These patients included four who underwent coronary bypass surgery for left ventricular power failure alone (three of four survived), two patients with acute rupture of papillary muscles resulting in massive mitral regurgitation (two survived acutely, although one died forty-one days postoperatively of a stroke), and one patient who was balloon-pumped because of refractory myocardial ischemia and survived revascularization alone.

All six of the survivors underwent successful operation, but three of the patients were not operated upon. Two arrived in profound cardiogenic shock and died before they could be resuscitated even to the point of undergoing coronary arteriography. The third patient was inoperable and gradually was weaned from balloon counterpulsation only to remain as a Class IV patient in profound congestive heart failure; he succumbed within two months without improvement.



Of further interest is the time factor in the institution of circulatory assistance in these patients; six of the thirteen patients transported (61.5 percent) had established acute anuric renal tubular necrosis at the time of arrival to our institution. Two of the six survivors were among this group; this represents a significant improvement in the previously reported high mortality existing with renal failure in such patients.<sup>17,18</sup>

If the patient is capable of maintaining reasonable tissue perfusion at a systolic arterial blood pressure of 80 mm. Hg. or greater, it is suggested that "ordinary transfer" of that patient be effected by physicians, nurses, and/or trained paramedics to a center capable of instituting IABP or other circulatory support systems immediately. On the basis of the experience outlined above, it no longer is suggested that "on the spot" IABP be instituted prior to transfer because of the predicted extremely low salvage rate in these patients. The timing of circulatory support is, obviously, of paramount importance. If too long a period of time passes, progressive myocardial necrosis and secondary organ system failure will occur, thereby precluding chances for ultimate survival. On the other hand, early recognition of refractoriness to routine supportive therapy and institution of early IABP can result in as high as a 40 percent survival in cardiogenic shock patients with or without mitral regurgitation, ventricular septal defect or left ventricular aneurysm.<sup>8</sup>

## References

1. Binder MJ, Ryan JA Jr, Marcus F, Mugler F Jr, Strange D, Agress CM: Evaluation of therapy in shock following acute myocardial infarction. *Am J Med* 18:622, 1955.
2. Cronin FP, Moore S, Marpole DG: Shock following myocardial infarction: A clinical study of 140 cases. *Can Med Assoc J* 93:57, 1965.
3. Malach M, Rosenberg BA: Acute myocardial infarction in a city hospital: III. Experience with shock. *Am J Cardiol* 5:487, 1960.
4. Helenstein HK, Brofman BT: The treatment of the hypotensive state accompanying myocardial infarction. *Modern Concepts in Cardiovas Dis* 20:104, 1951.
5. Mundth ED, Yurchak PM, Buckley MJ, Leinbach RC, Kantrowitz A, Austen WG: Circulatory assistance and emergency direct coronary artery surgery for shock complicating acute myocardial infarction. *N Engl J Med* 283:1382, 1970.
6. Mundth ED, Buckley MJ, Leinbach RC, DeSanctis RW, Sanders CA, Kantrowitz A, Austen WG: Myocardial revascularization for the treatment of cardiogenic shock complicating acute myocardial infarction. *Surg* 70:78, 1971.
7. Dunkman WB, Leinbach RC, Buckley MJ, Mundth ED, Kantrowitz AR, Austen WG, Sanders CA: Clinical and hemodynamic results in intra-aortic balloon pumping and surgery for cardiogenic shock. *Circulation* 46:465, 1972.
8. Mundth ED, Buckley MJ, Leinbach RC, Gold HK, Daggett WM, Austen WG: Surgical intervention for the complications of acute myocardial ischemia. *Ann Surg* 178:379, 1975.
9. Gold HK, Leinbach RC, Sanders CA, Buckley MJ, Mundth ED, Austen WG: Intra-aortic balloon pumping for ventricular septal defect or mitral regurgitation complicating acute myocardial infarction. *Circulation* 47:1191, 1973.
10. Mundth ED, Buckley MJ, Gold HK, Daggett WM, Leinbach RC, Austen WG: Intra-aortic balloon pumping and emergency coronary arterial revascularization for acute myocardial infarction with impending extensions. *Ann Thor Surg* 26:435, 1973.
11. Dilley RB, Ross J Jr, Bernstein EF: Serial hemodynamics during intra-aortic counterpulsation for cardiogenic shock. *Circulation Supplement III to Vols 47 and 48*, 1973, p. 99.
12. Leinbach RC, Gold HK, Dinsmore RE, Mundth ED, Buckley MJ, Austen WG, Sanders CA: The role of angiography in cardiogenic shock. *Circulation Supplement III to Vols 47 and 48*, 1973, p. 95.
13. Bluestein R, Editor: Transactions of the second meeting of users of Avco intra-aortic balloon pump. Cranberry New Jersey, Roche Medical Electronics, 1975.
14. Abel RM, Beck CH, Jr, Abbott WM, Ryan JA, Jr, Barnett GO, Fischer JE: Improved survival from acute renal failure following treatment with intravenous essential amino-acids and glucose: Results of a prospective, double-blind study. *N Engl J Med* 288:695, 1973.
15. Abel RM: Parenteral nutrition in the treatment of renal failure: In Fischer JE, Editor: *Total Parenteral Nutrition*. Boston, Little, Brown, 1976.
16. Abel RM: Total parenteral alimentation in the treatment of renal failure. Excerpta, Medica International Congress Series—*Total Parenteral Alimentation*: 367:125, 1976.
17. Abel RM, Buckley MJ, Austen WG, Barnett GO, Beck CH Jr, Fischer JE: Etiology, incidence, and prognosis of renal failure following cardiac operations: Results of a prospective analysis of 500 consecutive cases. *J Thorac Cardiovas Surg* 71:323, 1976.
18. Abel RM, Buckley MJ, Austen WG, Barnett GO, Beck CH, JR, Fischer JE: Acute postoperative renal failure in cardiac surgical patients. *J Surg Res* 20:341, 1976.

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**Usage in Pregnancy.** Safe use is not established. Should not be used in pregnant patients unless potential benefits outweigh possible hazards.

**PRECAUTIONS: Head injury and increased intracranial pressure.** Respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a pre-existing increase in intracranial pressure. Narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

**Acute abdominal condition.** These products or other narcotics may obscure the diagnosis or clinical course of acute abdominal conditions.

**Special risk patients.** Administer with caution to certain patients such as elderly or debilitated patients and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, or prostatic hypertrophy or urethral stricture.

**ADVERSE REACTIONS:** Most frequently include lightheadedness, dizziness, sedation, nausea, and vomiting; more prominent in ambulatory than in nonambulatory patients; some may be alleviated if patient lies down; others include: euphoria, dysphoria, constipation and pruritus.

**DRUG INTERACTIONS:** CNS depressant effect may be additive with that of other CNS depressants. See Warnings.

For symptoms and treatment of overdosage and full prescribing information, see package insert.

## Introducing **EMPRACET®** c CODEINE #4

Each tablet contains: codeine phosphate,  
60 mg (1 gr) (Warning—may be habit-forming);  
and acetaminophen, 300 mg.



### Our new non-aspirin/ codeine analgesic for moderate to severe pain.

New peach-colored Empracet c Codeine #4 offers a potent alternative for patients in whom aspirin is not indicated.

Unlike compounds containing oxycodone which afford comparable analgesia, new Empracet c Codeine #4 gives you CIII prescribing convenience—up to 5 refills in 6 months at your discretion (where state law permits). And, prescribing by telephone is permissible in most states. Moreover, new Empracet c Codeine #4 has less addiction potential than does oxycodone.

For those of your patients requiring a less potent analgesic, non-aspirin Empracet® c Codeine #3 provides effective relief of moderate pain.

**Burroughs Wellcome Co. makes codeine combination products. You make the choice.**



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# COLBY PROCLAIMS WOMAN SUFFRAGE

*Sigs Certificate of Ratification  
at His Home Without  
Women Witnesses.*

MILITANTS VEXED AT PRIVACY.

*Wanted Movies of Ceremony,  
But Both Factions Are*

WASHINGTON, Aug. 26, 1920—  
... struggle ... Wom-



# TRUMAN CLOSES UNITED NATIONS CONFERENCE WITH PLEA TO TRANSLATE CHARTER INTO DEEDS

## NEW WORLD HOPE

*President Hails 'Great  
Instrument of Peace,'  
Insists It Be Used*

HISTORIC LANDMARK

*Meeting Gives Standing  
Ovation as Executive  
Pictures Peace Gain*

"If we fail to use it," he declared to the solemn final meeting of the delegates, "we shall betray all of those who have died in order that we might meet here in freedom and safety to create it."

"If we seek to use it selfishly—for the advantage of any one nation or any small group of nations—we shall be equally guilty of that betrayal."

**Fervent Interpolation**

The President, speaking in the auditorium of the War Memorial Opera House, built in memory of sons of the Golden Gate city who gave their lives in the first World War, in which he himself served, seemed to give unconscious expression to the solemn feeling of the occasion when, at the outset of his speech, he interpolated the words, half a hope, half a prayer:

"Oh, what a great day this can be in history!"

Just before the plenary session

# Social Security Bill Is Signed Gives Pensions to Aged, Jobless

*Roosevelt Approves Message Intended to Benefit 30,000,000  
Persons When States Adopt Cooperating Laws—He  
the Measure 'Cornerstone' of His Economic Program*

## SENATE APPROVES 18-YEAR OLD VOTE IN ALL ELECTIONS

*Amendment to Constitution  
is Sent to House, Where  
Passage is Expected*

WASHINGTON, March 10, 1971—The Senate approved today, 94 to 0, and sent to the House for passage the amendment to the Constitution which would require a minimum age of 18 for all voters in all elections.

WASHINGTON, Aug. 15. The Social Security Bill, a broad program of unemployment insurance and old age and counted upon to benefit 20,000,000 persons, became law today when it was signed by President Roosevelt in the presence of those chiefly responsible for drafting it through Congress.

Mr. Roosevelt called the bill "the cornerstone of my economic program which is being built to help men's complete recovery from the depression."

# the Draft Ends No

WASHINGTON, Jan. 27, 1973—"With the signing of the peace agreement in Paris today, and after receiving a report from the





# PATIENT PACKAGE INSERTS: A CONCEPT WHOSE TIME HAS COME?

*The consumer's right to know is an irreversible and desirable trend of the Seventies. It extends, and properly, to a patient's right to know more about his or her prescription medications. One way, gaining favor, is through patient package inserts. Wisely prepared and properly distributed when medically indicated, they could markedly improve patient knowledge and drug therapy—laudable goals by anyone's standards.*

*The PMA endorses these goals and will work with government, the health professions and consumers to achieve them.*

## **The Advantages**

The concept holds promise of benefits: better patient understanding of the product prescribed, better adherence to the treatment plan, and more awareness of possible side reactions.

Every doctor has had patients who fail to finish antibiotic regimens because they feel better. Some patients assume that if one tranquilizer or analgesic is good, two may be twice as good. Still others fail to report dizziness while on antihypertensive therapy—and so on.

Problems like these might arise less often if the patient received written information in addition to verbal instructions. Some studies suggest that patients are more receptive to such materials, and they more often understand the verbal instructions and follow them, when inserts are used.

## **The Disadvantages**

There are also some potential problems. Obviously, the inserts must be clearly phrased, without extraneous or complex detail. How much information

is enough? How can it be kept current? Should all patients receive the same information? Should inserts be included with all drugs? Should only potential problems be listed or are patients better off with a "fair balance" presentation that describes usefulness as well as drawbacks?

These and similar questions require answers, since model inserts have yet to be properly developed and tested. Despite the need for these studies, the FDA is proceeding prematurely with inserts on selected products. We think the Congress is the only place where the matter can be given the proper legal status and direction, particularly since it represents a conceptual change in the legal, medical and social framework of the nation's prescription drug information system.

## **The Solution**

The PMA believes that carefully-devised pilot studies of various kinds of inserts are needed. They should be developed and implemented with full participation by doctors, pharmacists, consumers, communications experts and the drug industry. Such studies will provide reliable pathways to follow, so that inserts will be useful aids to medical practice.

And particularly we think that you should be closely involved in this debate and in these studies and decisions. Otherwise, people with less experience and qualifications may control the purposes, content and use of a tool with considerable promise for improved patient care. It could make a difference in your practice tomorrow, and more importantly, in the health of your patients.

**PMA**

THE PHARMACEUTICAL MANUFACTURERS ASSOCIATION  
1155 FIFTEENTH ST., N.W. WASHINGTON, D.C. 20005

*Subcutaneous mastectomy may be a useful procedure in the woman at high risk to develop breast cancer or in the patient who has intralobular or ductal carcinoma in situ. Data are lacking, however, to determine its prophylactic or curative value. Long-term information is very much needed but may be difficult to obtain.*

# Subcutaneous Mastectomy:\*

## Perspectives and Problems

**Robert M. Goldwyn, M.D.,  
Brookline, Mass.**

Since its first description in 1917,<sup>1</sup> the operation of subcutaneous mastectomy has undergone many vicissitudes, from oblivion to acceptability. The decisions involved in that procedure as well as the indications, advantages, and disadvantages merit analysis.

### Rationale and Indications

Bartlett<sup>1</sup> originally performed subcutaneous mastectomy for benign disease and preserved the areola-nipple complex and the skin envelope so that he could transplant fat in order to restore contour. Today, subcutaneous mastectomy is done to minimize deformity and usually to remove premalignant tissue before invasive carcinoma develops. Although the term "pre-malignant" is controversial, it includes ductal dysplasia (atypia), severe ductal hyperplasia, and papillomatosis. For some surgeons, it is the operation of choice for carcinoma *in situ*, intraductal and lobular.<sup>2</sup>

Because of the increased incidence of cancer developing in breasts with chronic cystic disease,<sup>3,4</sup> subcutaneous mastectomy has been advocated for that condition, particularly in women who have had repeated biopsies and have a strong family history of premenopausal breast cancer.

In women having had removal of the breast for carcinoma, subcutaneous mastectomy may be indicated for the opposite breast, whose probability of developing malignancy is about ten percent.<sup>2</sup> Should every woman with a history of unilateral breast cancer have a subcutaneous mastectomy? Should it be reserved only for

those with worrisome microscopic findings? These are questions whose answers must be individualized. However, if reconstruction is being done after unilateral mastectomy, subcutaneous mastectomy, to achieve symmetry and to prevent cancer, would seem more appropriate for the other side, if pendulous, then reduction mammoplasty. But here again, the patient and the surgeon must make that decision together.

Occasionally, subcutaneous mastectomy is recommended for mastodynia but primary psychological factors and dorsal radiculitis should be excluded.

Underlying the performance of subcutaneous mastectomy for premalignant disease is the assumption that with less mammary tissue present, the likelihood of developing mammary cancer is reduced, perhaps even proportionately. While seemingly logical and reasonable, this hypothesis has yet to be proved. At this time, data from long-term follow-up are lacking to assess the prophylactic worth of subcutaneous mastectomy.

### The Problem

Studies<sup>5</sup> in cadavers and patients have demonstrated residual breast tissue after subcutaneous mastectomy not only beneath the areola and nipple, as might be expected, but unpredictably at the margins of resection. With experience, the surgeon can perform a more extensive extirpation of mammary tissue, with coring of

\*Read before the Section on Plastic and Reconstructive Surgery, 211th Annual Meeting, the Medical Society of New Jersey, Atlantic City, May 15, 1977. Dr. Goldwyn is associate clinical professor of surgery, Harvard Medical School; Head of Plastic Surgery, Beth Israel Hospital; and Surgeon, Peter Bent Brigham Hospital, Boston.

the nipple, and can obtain biopsies of the margins for frozen sections to detect residual breast tissue in order to increase the yield. Despite these measures, both the surgeon and the patient must understand that the removal of breast tissue, nevertheless, is incomplete. Those who consider breast cancer a systemic disease would hold that the presence of even one mammary cell is sufficient to develop a malignancy under certain conditions, still not understood.

Despite more than a century of intensive breast surgery, we lack fundamental anatomical and oncological information. Why does the upper outer quadrant of the breast have a higher incidence of cancer? Is it due to the presence of more lobules and/or more active glands? Is the pectoral fascia penetrated by breast tissue? If so, to what extent and how frequently? Is it necessary to take the pectoral fascia in order to do a satisfactory subcutaneous mastectomy? What is the relative effectiveness in removing breast tissue by the various types of mastectomy: simple, subcutaneous, radical, modified radical?

### When the Reconstruction

Reconstruction immediately after subcutaneous mastectomy has the advantages of quickly correcting the deformity, thereby sparing the patient both psychological trauma and a financial burden since many insurances do not pay for another hospitalization if reconstruction were delayed. However, the silicone implant, which is the most common method of restoring the breast form, is more hazardous in a recent wound in which seroma, hematoma, infection, and skin necrosis are more likely to occur than in a completely healed wound. Infection, however, is surprisingly infrequent, being less than two percent even under the conditions of immediate reconstruction. Skin necrosis is more likely if the subcutaneous mastectomy has been done aggressively with the flaps having been thinned to remove as much breast tissue as possible. The thicker the flap, the easier and the better is the reconstruction; the thinner the flap, the better the patient's prognosis and survival may be since a more vigorous subcutaneous mastectomy has

probably been done. Without data, however, these statements regarding survival and prognosis are conjecture. To determine the likelihood of skin flap ischemia, intravenous fluorescein can be used.<sup>†</sup> The fluorescent areas, judged 15 to 20 minutes after administration, indicate sufficient blood supply. However, in black women and in patients with previous scars as well as darkly-pigmented areola and nipple, fluorescein findings may be difficult to interpret. An alternative is to delay insertion of the implant for three to four days after the subcutaneous mastectomy. The wound at the time of the subcutaneous mastectomy is closed with a few buried gut sutures, and drained; Steri-strips<sup>‡</sup> are applied to avoid skin sutures which may introduce bacteria along the tracks and engender more reaction along the suture line.

Every patient who has a subcutaneous mastectomy must be warned of the probability of abnormal firmness and contour of the reconstructed breast. For reasons still unclear, the implant may become surrounded by a thick scar which may contract and make the breast unpleasingly spherical and hard. Subpectoral placement of the implant has been tried to avoid this unfavorable result but it still may occur. Putting the prosthesis under the pectoral muscle is easier if the fascia is preserved but, as mentioned, removing the fascia may insure a better extirpation of the breast. Whether or not this is true has not been demonstrated by microscopic studies.

To decrease capsule formation of an excessive degree steroids have been employed, but they must be used carefully to avoid atrophy of the skin and later extrusion of the implant. If the breast becomes too hard after the implant, as frequently happens following augmentation mammoplasty, external manual compression may successfully split the scar and make the breast less firm. This type of capsulotomy after subcutaneous mastectomy is less effective than after augmentation mammoplasty. Occasional-

<sup>†</sup>Smith, Miller & Patch  
Division of Cooper Laboratories (P.R.)  
San German, Puerto Rico 00753

<sup>‡</sup>Minnesota Mining & Mfg. Company  
Medical Products Division 3M Center  
St. Paul, Minnesota 55101



ly, surgical release of the capsule which can be done under local anesthesia on an outpatient basis is needed and usually ameliorates the problem.

A word should be said about the resected specimen. To detect suspicious areas for microscopic analysis, x-rays are helpful and should be done prior to serial sectioning. The incidence of occult breast cancer following subcutaneous mastectomy is approximately six percent which is the incidence of breast cancer in the female population. Because of the possibility of finding unsuspected breast cancer, some surgeons change instruments, gowns, and gloves prior to beginning the second side.

### Follow-Up

Since every patient after subcutaneous mastectomy must be assumed to have residual breast tissue, she should be followed closely for the possibility of developing mammary malignancy. Clinical examination is a better means of following these patients than mammography, xeroradiography, or thermography. Occasionally, these methods provide help in localizing remaining mammary tissue or in the differential diagnosis of a "mass."

### Prognosis

As mentioned earlier, the degree of protection which subcutaneous mastectomy truly affords is still unknown. Pennisi and his associates<sup>8,9</sup> have reported a 0.5 percent incidence of carcinoma developing after subcutaneous mastectomy in patients followed up to 15 years. With a longer follow-up, the incidence will likely increase.

One might legitimately question the value of subcutaneous mastectomy since breast tissue is left behind. Why not do at least a simple mastectomy? Unfortunately, data are insufficient to judge the efficacy of simple mastectomy in terms of cancer prevention. The woman who is at high risk but without a definite mammary malignancy probably will be unwilling to accept the greater deformity of a simple mastectomy

compared to that of a subcutaneous mastectomy. Yet, because of the possibility that cancer will develop, both the surgeon and the patient might prefer subcutaneous mastectomy despite its limitations, because it is probably safer than examinations every three to four months, multiple aspirations, frequent biopsies, and repeated radiography.

### The Future

It is important that there be an orderly accumulation of data regarding subcutaneous mastectomy. To this end, a registry has been established at the Saint Francis Memorial Hospital in San Francisco. An intrinsic problem is that surgeons vary enormously in the performance and extent of subcutaneous mastectomy and pathologists differ widely in their interpretation of microscopic findings.

### References

1. Bartlett W: Anatomic substitute for the female breast. *Ann Surg* 66:208-211, 1917.
2. Wilson RE: Perspectives from a surgical oncologist. In: Goldwyn RM (Ed): *Plastic and Reconstructive Surgery of the Breast*. Boston, Little, Brown, 1976, pp. 431-440.
3. Haagensen CD: Editorial: The relationship of gross cystic disease of the breast and carcinoma. *Ann Surg* 185:375-376, 1977.
4. Monson RR, Yen S, MacMahon B, Warren S: Chronic mastitis and carcinoma of the breast. *Lancet* 2:224-225, 1976.
5. Goldman LD, Goldwyn RM: Some anatomical considerations of subcutaneous mastectomy. *Plast Reconstr Surg* 51:501-505, 1973.
6. Freeman BS: Subcutaneous mastectomy. In: Georgiade NG (Ed): *Reconstructive Breast Surgery*. St. Louis, Mosby, 1976, pp. 254-282.
7. Goldwyn RM, Goldman LD: Subcutaneous mastectomy and breast replacement. In: Goldwyn RM (Ed): *Plastic and Reconstructive Surgery of the Breast*. Boston, Little, Brown, 1976, pp. 441-453.
8. Pennisi VR, Capozzi A: The incidence of obscure carcinoma in subcutaneous mastectomy. Results of a national survey. *Plast Reconstr Surg* 56:9-12, 1975.
9. Pennisi VR, Capozzi A, Perez FM: Subcutaneous mastectomy data. A preliminary report. *Plast Reconstr Surg* 59:53-56, 1977.

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544 N



### Cardilate® (erythrityl tetranitrate)

**INDICATIONS.** For the prophylaxis and long-term treatment of patients with frequent or recurrent anginal pain and reduced exercise tolerance associated with angina pectoris rather than for the treatment of the acute attack of angina pectoris since its onset is somewhat slower than that of nitroglycerin.

**PRECAUTIONS.** As with other effective nitrites, some fall in blood pressure may occur with large doses.

Caution should be observed in administering drug to patients with a history of recent cerebral hemorrhage because of the vasodilation which occurs in the area. Although therapy permits more normal activity, the patient should not be allowed to misinterpret freedom from anginal attacks as a signal to drop all restrictions.

**SIDE EFFECTS.** No serious side effects have been reported. In sublingual therapy, a tingling sensation (like that of nitroglycerin) may sometimes be noted at the point of tablet contact with the mucous membrane. If objectionable, this may be mitigated by placing the tablet in the buccal pouch. As with nitroglycerin or other effective nitrites, temporary vascular headache may occur during the first few days of therapy. This can be controlled by temporary dosage reduction in order to allow adjustment of the cerebral hemodynamics to the initial marked cerebral vasodilation. These headaches usually disappear within one week of continuous therapy but may be minimized by the administration of analgesics.

Mild gastrointestinal disturbances occur occasionally with larger doses and may be controlled by reducing the dose temporarily.

**HOW SUPPLIED.** 10 mg chewable scored tablet in bottle of 100. Also 5, 10, and 15 mg oral/sublingual scored tablets in bottles of 100. 10 mg oral/sublingual scored tablets also supplied in bottles of 1,000.

Also available: Cardilate® P brand Erythrityl Tetranitrate with Phenobarbital® Tablets (Scored).

(\*Warning: may be habit forming.)



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"Our sex life is nil..." A problem of the first magnitude to many post infarct patients and their mates...patients are often reluctant to broach the subject; physicians may frequently overlook its implications. This new 16mm film combines candid patient interviews with discussions by Drs. Herman Hellerstein, Thomas Hackett, Albert Kattus, Richard Stein, Carroll Witten and Lenore Zohman. Film and related monograph comprise 2 AAFP credit hours. To arrange viewing, write Burroughs Wellcome Co., Educational Services Department, Research Triangle Park, N.C. 27709 or contact your B.W. Co.<sup>®</sup> representative.

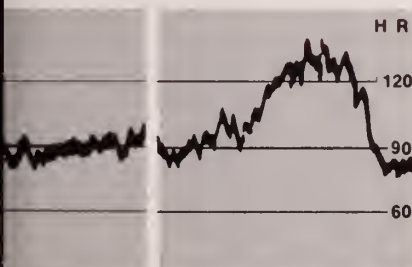
# Sex and the heart patient:

A film every doctor should see.

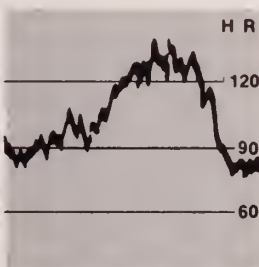
The energy cost of sex to the heart is relatively modest.

Over 80% of post-coronary patients ultimately resume sexual activity without serious risk. Hellerstein and Redman demonstrate that mean maximal heart rate during orgasm in spouse (as opposed to extramarital sex) in 14 post-infarct patients is lower than that during usual occupational activity.

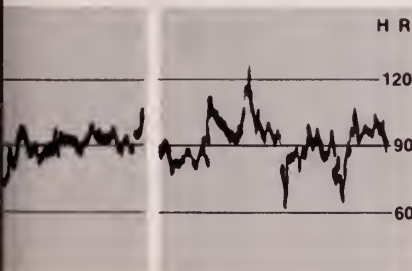
Presentations below of actual ECG readings of an attorney, post MI, illustrate the point:



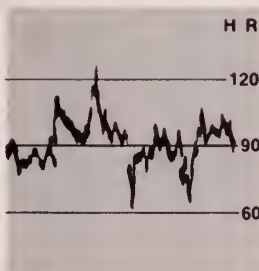
A Working in office (about 90 beats/min)



B Confrontation in judge's chamber (about 125 beats/min)



C Pre-orgasm sex activity (about 90 beats/min)



D Peaks at orgasm (120 beats/min)



Fear of pain greatest deterrent to post MI sex

In the multitude of MI patients with angina, pain is due to diminished coronary reserve and increased myocardial oxygen demand, precipitated by sex, other excitement and improper exercise. Anginal pain, however, can be relieved, and its recurrence mitigated.

**Cardilate<sup>®</sup> (erythrityl tetranitrate) increases exercise tolerance.**

Cardilate relieves anginal pain and prevents its recurrence, thereby allowing increased activity.

Commencing to work in as little as 2 to 5 minutes, Cardilate protects against recurrence of angina for at least 2 hours.

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# Cardilate<sup>®</sup>

(erythrityl tetranitrate)

*Here presented is a chart for determining the statistical significance of clinical data obtained from two equally sized groups of patients.*

## Assessment of Statistical Significance of Clinical Data

**Gavin Hildick-Smith, M.D.\* and  
R. L. Taetzsch, M.S., New Brunswick**

The practice of reporting clinical data without statistical evaluation is now diminishing. Physicians, however, still are faced with difficulty in determining whether impressive findings reported in some biological and clinical studies are, in fact, statistically significant. For this reason the attached chart was developed for easy, rapid determination of the statistical significance of clinical data obtained from two equal groups of patients in which response to therapy, toxic manifestations, and other parameters are reported.

The chart was developed by the use of a digital computer using Fisher's exact test and the chi-square test.<sup>1</sup> It is based on a 95 percent confidence level. It allows an investigator to determine whether a real difference exists between two groups under comparison with the understanding that in approximately one in every 20 instances the observed difference will have been a chance occurrence (Type I Error).<sup>2</sup>

The use of the chart best is illustrated by two examples (see chart). In the first example 64 percent of 50 patients treated with preparation A were cured, and 38 percent of 50 patients treated with preparation B were cured. To determine whether the difference in the two cure rates is statistically significant, use the following procedure:

1. Draw a vertical line originating at point 50 on the horizontal axis since there are 50 patients in each treatment group.

2. Locate the point on this line corresponding to the higher cure rate of 64 percent (see right margin). Since the 64 percent curve is not drawn on the chart, the location of the

64 percent line must be approximated.

3. Draw a horizontal line to the left vertical axis from the estimated point established in step 2.

4. Read the critical value on the left vertical axis (42 percent).

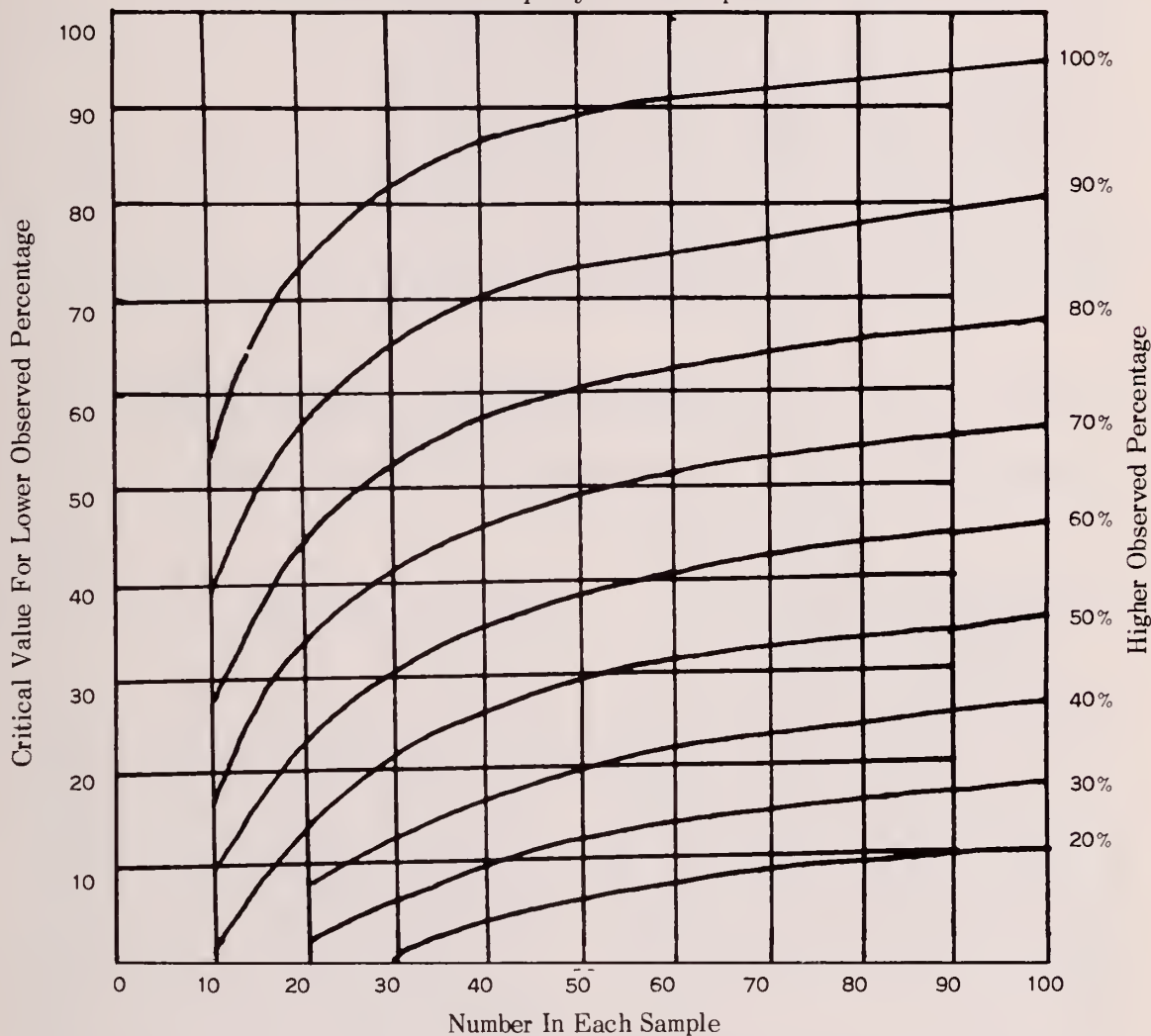
5. Compare the actual cure rate (38 percent) for the treatment group with the lower cure rate with the critical value determined in step 4 (42 percent). Since, the actual cure rate is less than the critical value, we conclude that there is a statistically significant difference between the two cure rates.

In a second example, the observed cure rates are 64 and 88 percent for two groups of 25 subjects each. Employing the procedure outlined above, the critical value for the higher cure rate was 59 percent. Since this critical value is less than the lower cure rate of 64 percent, the difference between the cure rates is not statistically significant. We may state correctly that the observed differences between the population cure rates are not large enough to demonstrate a statistical difference at the 95 percent confidence level. If, however, we should state that there is no difference between the cure rates this statement may be in error (Type II Error), especially with small samples.<sup>2</sup> The sample size required to keep Type II Error to a minimal level is mainly a function of the magnitude of the difference in cure rates. Very large differences can be detected with small samples but very large samples are required to detect small differences. For example, in order to keep the Type II Error below 10 percent a sample size of 42 subjects is required when there is a cure rate difference between two groups of 30 percent, while a sample of 400 subjects is needed with a cure rate difference of 5 percent.<sup>3</sup>

\*Dr. Hildick-Smith is Clinical Assistant Professor, Department of Pediatrics, CMDNJ, Rutgers Medical School, Piscataway.

### 95% Confidence Level Chart

For Obtaining The Statistical Significance Of the Difference in Percentages  
Obtained From Two Equally Sized Groups of Patients



### References

1. Armitage P: *Statistical Methods in Medical Research*. New York, Wiley, 1971, p. 131.

2. Feinstein AR: Clinical biostatistics XXXIV. The other

side of "statistical significance": Alpha, beta, delta, and the calculation of sample size. *Clin Pharmacol* 18(4):491-505, October, 1975.

3. Gail M, Gart JJ: The determination of sample sizes for use with the exact conditional test in 2 x 2 comparative trials. *Biomet* 29:441-448, September, 1973.

Johnson and Johnson, New Brunswick



*A study was made in 1974 of the incidence of acute myocardial infarction [AMI] in urban blacks among the residents of Paterson treated in hospitals in and around the city; the 1970 census was used for age, race, and sex-specific rates. Of the 162 documented cases among Patersonians, 17 were blacks; 27 percent of the total population of 144,824 was black. The crude rate per 100,000 of AMI among persons over 30 years was higher in the whites as a group (260) than in blacks (146). Whereas the overall incidence of AMI was higher in white males, there was no significant difference among the females. The age-specific rate, however, revealed higher incidence in blacks in the 30-39 (59 vs 29 per 100,000), 70-79 (673 vs 578) and 80-89 (613 vs 291) decades (all  $P$ 's < 0.02). The two groups differed insignificantly with respect to location, severity, complication and mortality from AMI. Smoking was the most frequent risk factor in the two groups (55 vs 18 percent for hyperlipidemia and 26 percent for hypertension). The blacks, however, had a higher prevalence of hypertension, 63 as compared to 23 percent in white ( $P$  < 0.0002). These data indicate that the rate of AMI in age-related blacks is actually higher than in whites. The reported rarity of AMI in blacks may be due to the fact that the black population is relatively younger.*

## Incidence of Acute Myocardial Infarction among Blacks in an Urban Community\*

**S. S. Ahmed, M.D., R. Rozefort, M.D.,  
and R. Brancato, M.D., Newark**

trace every case of myocardial infarction which occurred in Paterson in 1974.

Coronary artery disease has increased to epidemic proportions in this country as shown by estimates which suggest that one out of five males will develop coronary artery disease before reaching sixty. The estimated incidence for this malady in the USA is reported to be 320/100,000 for males and 90/100,000 for females.<sup>1</sup> The reported incidence of acute myocardial infarction in black persons has been substantially lower than that reported for caucasians.

Arterial hypertension, an accepted risk factor for the development of coronary artery disease, occurs more frequently in blacks than in whites.<sup>2-5</sup> In spite of this, the reason for the apparent rarity of myocardial infarction in blacks is not clear.

This study was designed to determine the incidence of acute myocardial infarction in black persons in an urban community—Paterson, New Jersey. From the State Department of Health statistics it was recognized that the residents in this town who developed an acute coronary episode were treated in the three in-town hospitals and did not seek admission to any out-of-town hospital. Thus, we were able to

### Method

All cases of acute myocardial infarction occurring among the Paterson residents of all races were traced from January 1, 1974 to December 31, 1974 regardless of the hospital in which they were admitted. By means of patient origin data supplied by the State Department of Health, we were able to ascertain that every single patient with a myocardial infarction occurring in Paterson was admitted to one of the three hospitals in town. All charts with the diagnoses of acute coronary disease, coronary thrombosis, and acute myocardial infarction at each hospital were reviewed for confirmation of the diagnosis. The diagnosis of acute myocardial infarction was accepted when diagnostic Q waves were present with positive serial values for myocardial enzymes; a non-transmural infarction was diagnosed when the ST-T depression or new T wave inversion occurred and remained for at

\*From the Department of Medicine, St. Joseph's Hospital, Paterson and CMDNJ-New Jersey Medical School, Newark. Supplemented by research grant (GR 2ES75) from Essex County Heart Association affiliate, American Heart Association. Presented in part at the 10th Inter-American Congress of Cardiology, Caracas, Venezuela, September 1976. Martin Feuer rendered technical assistance in the standard analysis of the data.

least 48 hours along with the elevation of cardiac enzymes, but without development of a new Q wave.

These charts were then tabulated according to patient's age, sex, race, and survival. In order to determine the rate per hundred thousand, the 1970 census for Paterson was utilized.

The statistical analyses were performed using the t test for actual numbers of patients within each group and the 1970 population figures.<sup>6</sup> A modified McNemar's chi square test was used for determining the incidence of risk factors.<sup>7</sup> This method which also is known as the "repeated testing of the same individuals" or "testing for correlated proportions," measures the same samples of individuals when exposed to two or more risk factors. Fisher's exact test was used for very small samples for measuring the differences between the two groups.<sup>6</sup>

## Results

There were 800 patients with acute myocardial infarction who were admitted with that diagnosis in the three hospitals in Paterson in 1974. Of these, 175 were residents of that city. As no Paterson resident was admitted with the diagnosis of acute myocardial infarction in any out-of-town hospital, these were considered the total cases occurring in this town in one year. Only 162 black and caucasian individuals were analyzed since the rest were either of Hispanic or other racial background and few in number. Of these 162, 145 were white (91 males, 54 females), and 17 were black (7 males, 10 females). The crude rate per 100,000 was 260 in whites and 146 in blacks ( $P < 0.005$ ). The crude rate per 100,000 was much higher in white males (346) than in white females (178) and in blacks (138). There was no difference between the females of the two races or between the two sexes among the blacks (Figure 1).

Of the 144,824 people in Paterson, blacks totaled 38,919 or 27 percent. In contrast to whites in whom 46 percent of the population was under 30, 68 percent of the blacks were 30 years or younger (Figure 2). To evaluate this difference, the rate of myocardial infarction was calculated in each decade. The incidence of myocardial infarction calculated per 100,000 in each decade appears to be significantly higher in the blacks at the 30-39 and 70-79 years of age (Figure 3).

## INCIDENCE OF MYOCARDIAL INFARCTION BY RACE AND SEX

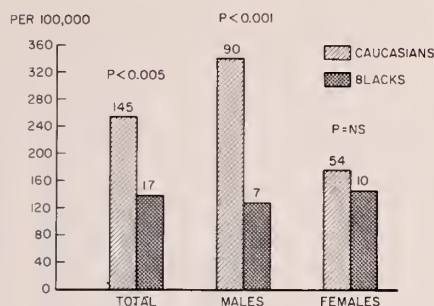


Figure 1—Incidence of myocardial infarction per hundred thousand calculated according to race and sex. Figures at the top of the bars are actual number of cases.

## PATERSON POPULATION (1970) DISTRIBUTION BY RACE AND AGE

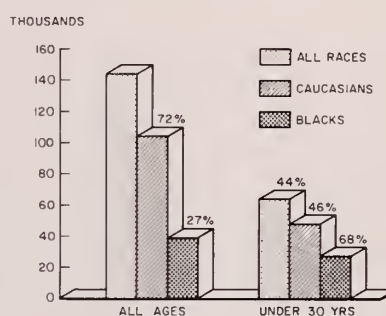


Figure 2—The Paterson population (1970 census) with distribution according to race and age.

These cases were further analyzed to uncover any differences in the clinical characteristics, risk factors, and so on. These two groups differed insignificantly as to duration and character of pain, physical findings, or the levels of cardiac enzymes. There were no differences between the two groups with respect to location of myocardial infarction. Mortality figures were essentially similar: 16 percent for whites and 11.8 percent for blacks.

Analysis of the risk factors disclosed that smoking was the most frequent risk factor in the two groups. Whereas 55 percent of the population smoked, only 26 percent had hypertension and 18 percent had hyperlipidemia. McNemar's chi square test for testing of correlated proportion was highly significant at a level of 0.001 for both smoking and hypertension. Diabetes was more frequent than hyperlipidemia in both groups. Except for hypertension, which was significantly more frequent in blacks, risk factors did not differ significantly for the two groups.

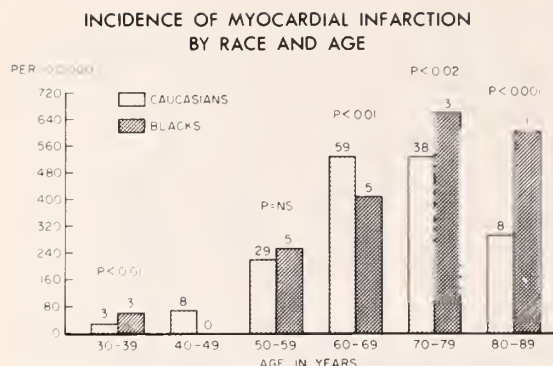


Figure 3—Age-specific incidence of myocardial infarction in the two races.

## Discussion

Published reports which describe the incidence of coronary disease in blacks were all derived from autopsy data.<sup>8-10</sup> No attempt was made in any of these studies to relate the number of myocardial infarctions to the base population. The calculation of incidence of disease of a particular age group requires evaluation of the population at risk and the actual number of cases occurring in that base population irrespective of the place where they were confined during their acute episode. The only study that attempted to relate to the base population was that of Oalman, who compared blacks and whites using a population attending a particular parish in the inner city.<sup>8</sup> However, true incidence cannot be derived in a city by using a pre-selected group to the exclusion of the remainder. Since an older age group is more likely to attend a given church, the true incidence of myocardial infarction validly cannot be based on a study of incidence among attendants.

The reported lower incidence of coronary artery disease in the African Bantu may be real because there is a lack of atheromatous disease among this group, possibly related to the diet.<sup>11</sup> No such difference in the production of atheroma has been described in the American black. Apparently the risk factors for blacks and whites in this country are essentially similar. Furthermore, hypertension is well known to be more prevalent among the blacks.<sup>5</sup> The reasons for the lower incidence of myocardial infarction in the 40-49 and 50-59 age groups in our study is not clear from our data. In a parallel study of

a similar nature carried out in Newark, New Jersey, Weiss noted a higher death rate out of the hospital from coronary heart disease among blacks.<sup>12</sup> This may pertain to our Paterson population.

It is clear from this study that the age-specific incidence of acute myocardial infarction in our group was actually higher in blacks than in whites. The reported rarity of AMI in blacks may be due to a relatively younger population or to the failure of studies to include deaths from AMI in black persons out of hospitals.

## References

1. Stamler J: Epidemiology of coronary heart disease. *Med Clin N Amer* 57:5-46, 1973.
2. McVay LV Jr, Kiel PG: Myocardial infarction with special reference to the Negro. *Arch Int Med* 96:762-767, 1955.
3. Keil PG, McVay LV Jr: A comparative study of myocardial infarction in the white and Negro races. *Circulation* 13:712-718, 1962.
4. Thomas, WA, Blanche O, Lee KT: Race and incidence of acute myocardial infarction. *Arch Int Med* 100:423-429, 1957.
5. Schoenberg JA, Stamler J, Shekelle RB, Shekelle S: Current status of hypertension control in an industrial population. *JAMA* 222:559, 1972.
6. Dixon WJ, Massey FJ: *Introduction to Statistical Analysis*. New York, McGraw Hill, 1969.
7. Sokal RR, Rohlf FJ: *Biometry*. San Francisco, W.H. Freeman & Co. 1969, pp 611-617.
8. Oalman MC, McGill HC Jr, Strong JP: Cardiovascular mortality in a community: Results of a survey in New Orleans. *Am J Epid* 94:546-555, 1971.
9. Thomas WA, Blanche JO, Lee KT: Race and the incidence of myocardial infarction. *Arch Int Med* 100:423-429, 1957.
10. Kane WC, Aronson SM: Cerebrovascular disease in autopsy population. I. Influence of age, ethnic background, sex and cardiomegaly upon frequency of cerebral hemorrhage. *Arch Neurol* 20:514-526, 1969.
11. Schrire V: Heart disease in southern Africa with special reference to ischemic heart disease. *S Afr Med J* 47:634-644, 1971.
12. Weiss AB, Abiuso PD, Thind IS: Acute myocardial infarction in Newark, New Jersey. A study of racial incidence. *Arch Int Med* (in press).

65 Bergen Street, Newark



# CASE REPORTS

*A case of methylphenidate (Ritalin®) abuse is presented. The need for careful examination of fundi, pulmonary, and vascular findings is stressed. Complications of foreign body granulomata, osteomyelitis, pulmonary hypertension, and embolization are discussed. The possibility of granulomata occurring on heart valves should be kept in mind, and these patients should be examined carefully for evidence of bacterial endocarditis. Certain diagnostic and laboratory procedures such as pleural biopsy will aid in early diagnosis.*

## Methylphenidate (Ritalin®) Abuse\*

**Patrick D. Abiuso, M.D. and  
S. Pandarinath, M.D., Camden**

The many deleterious medical sequelae associated with intravenous drug abuse have been described by a number of authors<sup>1,2</sup>. An increasing use of methylphenidate (Ritalin®) among addicts on methadone maintenance programs has been reported by Willey<sup>3</sup>, and Raskind and Bradford<sup>4</sup>. The present case illustrates several complications arising in one patient.

### Case Report

A 26-year-old male was admitted to Cooper Medical Center with a ten-day history of cough, pleuritic chest pain, fever, and chills. Prior to admission he had been treated by his local physician with a ten-day course of oral penicillin with no clinical improvement. The patient, a known addict for many years and currently on a methadone program for narcotic withdrawal, admitted to recent intravenous use of Ritalin®. His only significant past history was that of hepatitis five years earlier.

Physical examination revealed a well-developed male in no acute respiratory distress. Except for a temperature of 101°F his vital signs were within normal limits. Examination of the head, eyes, ears, nose, and throat were within normal limits. Cardiac examination revealed normal heart sounds except for a grade 2/6 ejection systolic murmur at the apex with no transmission to the carotids or axillae.

There were decreased breath sounds and diminished vocal resonance at the right lung base. The abdomen was soft with no splenomegaly. Extremities revealed some needle tract marks and puncture wounds.

Initial laboratory studies revealed a hemoglobin of 13.6 grams and white blood count of 12,800 with a shift to the left. A gram stain of sputum revealed a few polymorphs but no organisms. The remaining studies included six negative sputum cultures for tuberculosis, a positive PPD skin test with a 19 mm. induration, positive VDRL, but a non-reactive FTA.

The patient continued to be febrile for the next three days and a pleural biopsy was performed. The biopsy revealed

multiple foreign body granulomas (Figure 1) and birefringent particles under a polarizing microscope (Figure 2). No evidence of tuberculosis was found in these specimens. The blood cultures drawn on admission grew out alpha hemolytic streptococci in two sets of bottles. The physical examination of the patient remained unchanged.

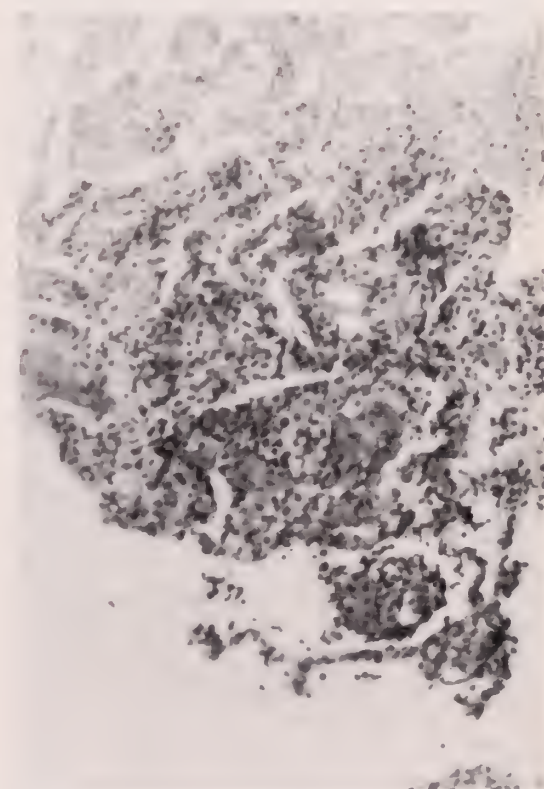


Figure 1 — Foreign body granuloma (low-power)

On the eleventh day of admission, the patient again injected Ritalin® while still in the hospital and started complaining of pain bilaterally in his ankles and back. His ankles became swollen and hot and there was tenderness over the first and second lumbar spines. A Gallium bone scan was performed which showed "blastic activity" over the left femur, left shoulder, and left maxilla. A repeat scan ten days later was unchanged. A scan for the bone marrow using 99 TC sulfur colloid was performed to dis-

\*This case report is from the Cooper Medical Center, Camden.

tinguish bone infarcts from osteomyelitis, and the results were interpreted as being consistent with osteomyelitis.

The patient was treated for bacterial endocarditis and osteomyelitis with 20 million units of penicillin daily for six weeks and one gram of streptomycin daily for two weeks, followed by 0.5 gm daily for four more weeks. The patient was asymptomatic after a full course of intravenous antibiotic therapy. Repeat bone scan was unchanged and the chest x-ray was clear at the time of discharge.

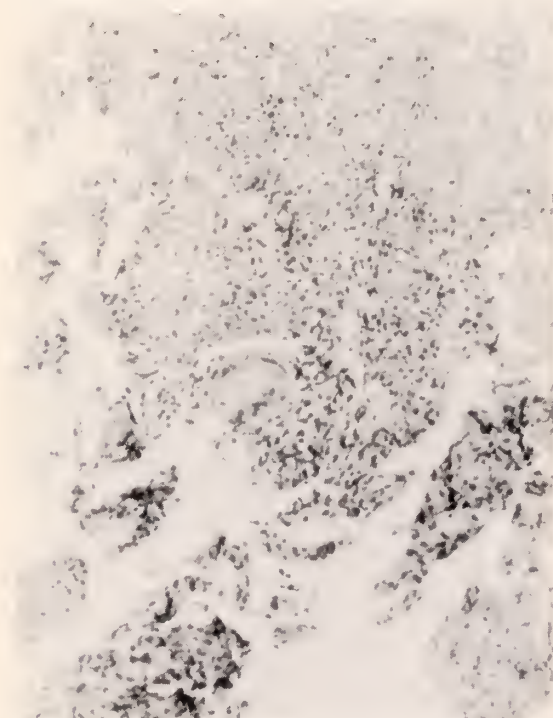


Figure 2—Birefringent particles under polarizing microscope

### Discussion:

Ritalin® is a mild stimulant and antidepressive drug, which in high doses, acts similarly to amphetamines. The practice of Ritalin® abuse is known as "West Coast" among addicts.<sup>3</sup> Most of them administer ground tablets intravenously. There is an apparent additive "high" using it in this manner. Granulomas similar to talc granulomas have been described in such addicts. Indeed the granulomas are thought to result from talc particles from Ritalin® tablets. Hahn and Schwad<sup>4</sup> describe biopsies from a number of patients, including a patient with endocarditis who had typical granulomatous lesion over her tricuspid valve. The authors raise the interesting question about the role of these granulomata on the tricuspid valve in the

pathogenesis of endocarditis. Similar granulomas have been observed with the intravenous use of other drugs experimentally.<sup>6,7</sup>

Our case revealed complications of Ritalin® abuse namely, (1) osteomyelitis of several bones, (2) granulomatosis of the lung with a superimposed streptococcal pneumonia, and (3) possible emboli from heart valves to the lungs and bone.

### Conclusion

Addicts on methadone programs should be checked carefully for evidence of early pulmonary hypertension and the presence of granulomas in the fundi.<sup>8</sup> The urine should be screened for the presence of Ritalin® particles. Pleural or lung biopsies in patients where there is a suspicion of pulmonary involvement enable early recognition of this problem which appears to be increasing in frequency among drug abusers.

### References

1. Louria DB, Hensle T, Rose J: The major medical complications of heroin addiction. *Ann Intern Med* 67:1-22, 1967
2. Joseph WL, Fletcher HS, Giordona JM, Adkins PC: Pulmonary and cardiovascular implications of drug addiction. *Amer Thor Surg* 15:263-273, 1973
3. Willey RA: Abuse of methylphenidate (Ritalin®). *N Engl J Med* 285:464, 1971
4. Raskind M, Bradford T: Methylphenidate (Ritalin®) abuse and methadone maintenance. *Dis Nerv Sys* 36:9-12, 1975
5. Hahn HH, Schweich AI and Beaty HN: Complications of injecting dissolved methylphenidate tablets. *Arch Int Med* 123:656-659, 1969
6. Hopkins GB, Taylor DC: Pulmonary talc granulomatosis—A complication of drug abuse. *Amer Rev Resp Dis* 101:101-104, 1970
7. Puro HE, Wolf PL, Skergandos J, Vasquez J: Experimental production of human "blue velvet" and "red devil" lesions. *JAMA* 197:1100, 1966.
8. Atlee Jr, WE: Talc and cornstarch emboli in eyes of drug abusers. *JAMA* 219:49-51, 1972.
9. Lewman LV: Fatal pulmonary hypertension from intravenous injection (Ritalin®) tablets. *Human Pathol* 3:67-70, 1972.

624 Mercer Street, Cherry Hill

*A case of carcinoma of the common hepatic duct is presented. Because of incasement of the portal vein and hepatic artery, resection was not possible. A Niloff vitallium tube was used as a permanent internal stent after failure with a "T" tube. The procedure was judged to provide a good palliative result.*

## Palliation of Non-Resectable Carcinomas of the Extrahepatic Duct System

**Cono Pecora, M.D., Sam Khanna, M.D.,  
and Frank P. Gradone, M.D., Belleville**

Extrahepatic ductal obstruction by carcinoma is a difficult diagnostic and therapeutic problem for the operating surgeon. The management of a patient with common hepatic duct carcinoma is presented.

### Report

A 66-year-old male was admitted to Clara Maass Memorial Hospital on August 1, 1974 with a clinical diagnosis of obstructive painless jaundice. He had been hospitalized for jaundice 20 years prior to this admission but more recently he had a three-year history of vague, right, upper-quadrant abdominal pain.

He denied receiving blood transfusions and injectable medications during the past year. Prior to this admission he ate raw clams after which he complained of pruritus. Jaundice, light stools, and dark urine were present for one week prior to admission.

Pertinent laboratory findings on admission were as follows: total bilirubin—9.0 mg/dl; alkaline phosphatase—230 mu/ml; SGOT—132 mu/ml; SGPT—69 int. units, WBC = 3,800 with a normal differential. On August 3, 1974, the total bilirubin was 12.4 mg/dl (direct of 8.1 and indirect of 4.3). Urobilinogen was 4.0 Ehrlich U/100 ml. The direct Coombs and Australian antigen were negative.

On August 12, laparotomy revealed an obstructing lesion of the common hepatic duct which involved the right and left hepatic ducts and extended up into the liver. Incasement of the hepatic artery and the portal vein was also demonstrated. The liver was pigmented, however normal in size, shape, and position. Frozen section biopsy of the common hepatic duct mass was reported as adenocarcinoma. The obstructing lesion was dilated using Bakes dilators and a "T" tube was placed across the obstruction as an internal stent (Figure 1), and a cholecystojejunostomy was performed for drainage. The postoperative course was uneventful. The bilirubin went from a preoperative high of 20 mg/dl to 6.1 mg/dl on the day of discharge with the "T" tube in place. Treatment was with combined radiotherapy and chemotherapy.

The patient was readmitted to Clara Maass Memorial Hospital on September 23, 1974 with a diagnosis of ascending cholangitis and a bilirubin of 5.5 mg/dl. Culture and



Figure 1



Figure 2



sensitivity of the bile revealed *E. coli* and the blood culture was negative. The patient responded well to antibiotic therapy. A repeat "T" tube cholangiogram showed no change in the radiographic findings. The bilirubin was 5.1 mg/dl and the patient was discharged to outpatient follow-up. Prior to radiotherapy, a repeat "T" tube cholangiogram revealed no dye going proximally into the hepatic radical (Figure 2). The bilirubin began to rise, stools were clay colored, and the urine became port wine in color. On October 27, 1974 the patient was readmitted to the Clara Maass Memorial Hospital because of obstructive jaundice. The bilirubin was 13.6 mg/dl and the alkaline phosphatase was 266. The patient was reoperated on November 1, 1974. Laparotomy at this time demonstrated the common duct to be completely obstructed above the upper limb of the "T" tube. The "T" tube was removed and a Niloff vitallium tube (Figures 3 and 4) was placed across the obstructing lesion after a passage was made using Bakes dilators. The gallbladder was removed, the cholecystojejunostomy anastomosis taken down, and the jejunal opening closed.

Cholangiogram was taken through the "T" tube which had been placed within the (Niloff) tube. The postoperative course was free of major complications. On November 13, 1974 a "T" tube cholangiogram showed a free flow of bile both proximally and distally. (Figure 5) On November 18, 1974, the "T" tube was removed and the patient was discharged to office follow-up. Since discharge the patient has had several episodes of cholangitis which were successfully treated with antibiotics at home.

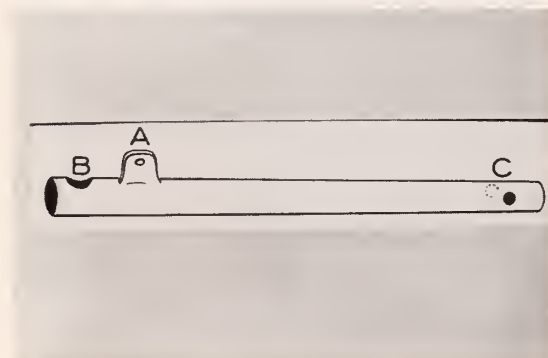


Figure 3

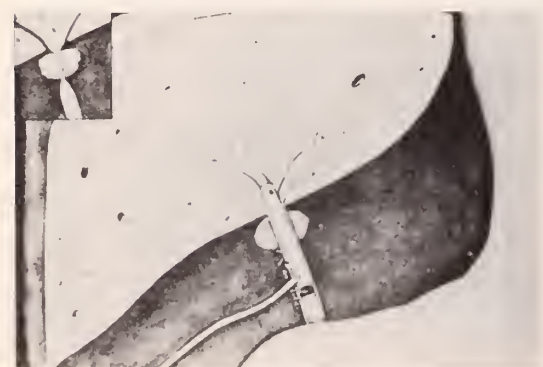


Figure 4



Figure 5

## Discussion

Schupple *et al.* recognized the first case of carcinoma of the hepatic ducts in 1878. W. J. Mayo<sup>4</sup> is credited with the first successful resection of primary carcinoma of a biliary duct in 1903.

Carcinoma of the extrahepatic ducts is relatively infrequent. Neibling, *et al.*<sup>1</sup> reported an incidence of 0.26 percent in 12,000 autopsies and 0.5 percent in 14,000 operations on the biliary tract. Glenn and Hill<sup>2</sup> reported 41 carcinomas of the ductal system including the Ampulla of Vater in a combined autopsy and surgical study. The infrequency of common bile duct carcinoma also was noted in a study by Quattlebaum, Jr.<sup>3</sup> Metastasis to the liver appears to occur relatively late, however, in the course of its development, the presence of jaundice usually carries a poor prognosis.

The preoperative diagnosis is seldom made and

the operative diagnosis is not easy. Although the disease is difficult to diagnose percutaneous cholangiogram or "T" tube cholangiogram are procedures that may offer considerable diagnostic help.<sup>4</sup> Malignant tumors of the hepatic ducts produce obstruction early in the course of the disease; they are slow growing and metastasize late. Distinct metastases may remain absent, and palliative procedures have been associated with surprisingly long periods of survival. Carcinoma of the major hepatic ducts is seldom considered as a cause of obstructive jaundice, but does occur often enough for any surgeon to come upon it unexpectedly at laparotomy. We believe one should take an aggressive approach to the problem and attempt to eradicate the disease if possible. If not, then a palliative procedure such as a by-pass should be tried.<sup>5,6,7</sup> One patient operated by Altomeier lived five and a half years; repeat exploratory laparotomy showed no extension beyond the

primary site.<sup>4</sup>

## References

1. Neibling HA, Dockerty MD, Waugh JM: Carcinoma of the intrahepatic bile ducts. *Surg Gynec Obst* 89:429-1949.
2. Glenn F, Hill MR Jr: Extrahepatic biliary tract cancer. *Cancer* 8:1218, 1955.
3. Quattlebaum JK Jr: Malignant obstruction of the major hepatic ducts. *Ann Surg* 876-889 (June) 1965.
4. Mayo WJ; *Malignant Disease of the Common Bile Duct*. Philadelphia, Saunders, 1912, p. 401.
5. Aldrete JS: Malignant neoplasms of the extrahepatic bile ducts. *Amer Surg* 37:613-621; (Oct.) 1971.
6. Terblanche J; "T" tube drainage in the palliative therapy of carcinoma of the main hepatic duct junction. *Surg Clinics of North America* 35:820, (October) 1973.
7. Alexander, *et al*: Surgery in cancers of the intrahepatic ducts. *Chirurgie* 99:252, (May) 1973.

Franklin Avenue, Belleville

## Alcoholism More Dangerous to Women than Men

Alcoholism is more damaging to women than to men, says a report in the July issue of the AMA's *Archives of Internal Medicine*.

Scientists at the University of Toronto, Canada, report on a study of physical disease profiles of 135 female and 737 male alcoholics, similar in age, social class, and referral pattern. Although the women had been drinking hazardously for fewer years, the prevalence of most diseases was similar in men and women, says Mary Jane Ashley, M.D., and colleagues. There was an excess of anemia in women, and an excess of fatty liver and chronic obstructive lung disease in men. Women had double the frequency of cirrhosis of the liver.

The average duration of hazardous drinking before the first occurrence of almost all illness events was shorter in women, 14.1 years to 20.2 years. "These findings suggest that the development of physical morbidity in relation to hazardous drinking may be accelerated in women," Dr. Ashley concludes.

There are indications that the incidence of alcoholism in women is increasing. The suggestion that the development of physical morbidity may be accelerated in female compared to male alcoholics should be a cause for concern and a stimulus for the further clarification of sex differences in the physical disease consequences of alcoholism, she says.

*The unusual features of a patient with blunt chest wall trauma are described. Correct diagnosis of life-threatening pericardial tamponade, emergency pericardial decompression, and definitive repair of a tear of the right atrial appendage saved the patient's life.*

## Tear of Right Atrial Appendage Following Blunt Chest Wall Trauma

**Barry B. Galton, M.D., Wayne**

Rupture of the heart has been reported in chest wall trauma, with and without direct laceration of the heart,<sup>1,4</sup> and with crush injuries to the lower trunk and legs. In the latter cases it is presumably secondary to sudden sharp increase in venous return and rapid increase in right atrial pressure.<sup>5,6</sup> The free wall of the right ventricle is the most common chamber involved with direct trauma, followed by left ventricle, right auricle, and left auricle in that order. Aortic laceration also may occur with blunt chest trauma and sudden deceleration injuries, with the most common site being at the Ligamentum Arteriosum.<sup>7</sup> In many cases signs of external chest trauma may be absent.<sup>8</sup>

In our review of the literature we failed to find mention of laceration of the right atrial appendage and associated involvement of the innominate artery. This case report describes a patient with both.

### Case Report

A 23-year-old female was brought to the emergency room of Chilton Memorial Hospital, Pompton Plains, New Jersey after her auto hit a tree. She was not known to be a drug or alcohol abuser and past history was negative. Examination revealed pulse 120, BP 70/50, and respirations 18. Superficial lacerations of the head and flat neck veins were noted. The anterior chest was minimally bruised but the lungs were clear; heart sounds were normal without murmur, rub, or gallop. The abdomen was tender in both upper quadrants with decreased bowel sounds, but there was no organomegaly. Peripheral pulses were good except the right radial artery which was decreased. Hematocrit was 30, Hgb 9.0, and WBC 27,000. EKG revealed only sinus tachycardia. Chest x-ray showed enlargement of vascular density in right medial infraclavicular area but normal heart and lungs. After infusion of 3000 cc of Ringer's lactate solution, the blood pressure rose to 140/90.

The patient was transferred to the intensive care unit. The attending surgeon's working diagnosis was intra-abdominal

hemorrhage with probable ruptured spleen, but abdominal taps on four attempts revealed only small amounts of light-pink stained fluid. Neck vein distension two and a half hours after admission suggested cardiac tamponade. A thoracic surgeon removed 100 cc of non-clotting pericardial blood via a sub-xiphoid approach. A catheter was placed via the left subclavian vein and the central venous pressure measured 180 mm saline; the pulse dropped from 156 to 135 and the patient's condition became stable.

Due to absent right brachial pulse, damage to the innominate artery or aortic root was suspected. Because of the possible need for immediate thoracotomy at a center with pump stand-by, it was decided to transfer the patient to St. Michael's Hospital, Newark. Before transfer, pericardiocentesis was repeated and an intracath<sup>®</sup> was inserted and left in the pericardium in case the CVP rose and repeat aspiration was necessary during the trip by ambulance. A cardiac monitor was attached and an I.C.U. nurse was in attendance. The trip was uneventful.



*Figure 1 - Portable x-ray on day of admission showing increased vascular shadow in right superior mediastinum.*





Figure 2—Aortogram showing intramural hematoma in innominate artery and luminal narrowing, secondary to intimal tear.

At St. Michael's Hospital, an emergency aortic root angiogram revealed hematoma of the ascending aorta and kinking of the innominate artery, thought to be due to torsion caused by the hematoma. Thoracotomy revealed a fractured sternum, ruptured right atrial appendage, hemopericardium, and hematoma of the innominate artery and ascending aorta. The atrial appendage was ligated; bleeding was controlled and the wound closed. With drainage of the pericardium and ligation of the right atrial appendage, the right brachial pulse returned to full force without specific therapy to the innominate artery.

The patient then underwent laparotomy, and a partial laceration of the right ovarian vein and laceration of the liver were found and sutured. Despite the extensive trauma and surgery, the patient made an uneventful recovery and was discharged on the eleventh hospital day.

### Comment

This case illustrates the fact that, although the initial findings pointed to major abdominal trauma, the life-threatening injury (pericardial tamponade) soon became evident, with neck vein distension and absent right brachial pulse, even though the external chest trauma appeared minimal and initially was considered trivial. The laceration of the right atrial appendage is distinctly unusual according to our review of the literature, and the association with innominate and aorta hematoma has not been noted previously.

The use of a pericardial catheter for pericardial decompression during transfer to a center with open heart facility has not been reported before. It provided a method for successful transfer of a critically ill patient from a community hospital to a nearby university hospital center where definitive cardiovascular repair was possible.



Figure 3—Chest x-ray 17 months after accident—normal except for minimal pleural reaction to right apex.

### Follow-up

The patient was seen in follow-up 17 months after the accident. Pulse was 68 and regular, BP 112/64 right brachial, 110/60 left brachial. Supraclavicular and peripheral pulses were normal throughout. The lungs were clear. There was a short systolic adventitious sound over the precordium. No definite cardiac murmur was noted. EKG showed T-wave inverted and coved V 1-2 and was considered a normal pattern for her age. Chest x-ray now shows minimal pleural reaction at the right apex. The heart and aorta appear normal.

The patient had had plastic repair of her original sternal-splitting scar six months after the accident. She is feeling well and working full time.

### References

1. Clinicopathological Exercises—Massachusetts General Hospital: Case 3-1976. *N Engl J Med* 294:152-158, 1976

2. Parmley LF, Manion WC, Mattingly TW: Nonpenetrating traumatic injury of the heart. *Circulation* 18: 371-396, 1958
3. Kissane RW: Traumatic heart disease—nonpenetrating injuries. *Circulation* 6:421-425, 1952
4. Kohn RM, Harris R, Gorham LW: Atrial rupture of the heart. *Circulation* 10:221-231, 1954
5. Bright EF, Beck CS: Nonpenetrating wounds of the heart. *Am Heart J* 10:293-321, 1935
6. O'Sullivan MD, Spagna PM, Bellinger SB, Doohen DJ: Rupture of the right atrium due to blunt trauma. *J Trauma* 12:208-214, 1972
7. Parmley LF, Mattingly TW, Manion WC: Nonpenetrating traumatic injury to aorta. *Circulation* 17: 1086-1101, 1958
8. Lasky IS, Nahum AM, Siegal AW: Cardiac injuries incurred by drivers in automobile accidents. *J Forensic Sci* 14:13-33, 1969

1777 Hamburg Turnpike, Wayne

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THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY

P.O. Box 904, Trenton, New Jersey 08605

*The purpose of this communication is to report a case of simultaneous bilateral and complete rupture of the quadriceps extensor mechanism as well as to discuss the pathophysiology and treatment of this rare event.*

# Simultaneous Bilateral and Complete Rupture of the Quadriceps Extensor Mechanism

**R. M. Pejic, M.D., E. R. Principato, M.D.  
and B. Liepa, M.D., Camden**

Bilateral ruptures are about 15 to 20 times less common than unilateral ruptures of the quadriceps tendons. However, because of the steady increase in the geriatric population all over the world, the authors feel that this particular problem will emerge from its inconspicuous position and become a recognizable entity in medicine and surgery. The chronic debilitating diseases, which are more common among the aged, are usually responsible for the degenerative changes causing weakness of the musculotendinous tissue and subsequent rupture when exposed to undue stress.

## Historical Aspects

Galen<sup>1</sup> was the first to record a rupture of the quadriceps tendon and, according to Conway<sup>4</sup>, Lister was the first to repair the quadriceps tendon surgically in 1878. Since antiseptics were not available prior to that time, this problem was treated only medically. In 1887, McBurney<sup>2</sup> published the results of the first operated case in American literature. He approximated the tendon using catgut suture and silver wire, with drill holes in the patella, to reinforce the attachments.

To date about two hundred cases of quadriceps tendon rupture have been reported in the literature, the largest series being by Walker<sup>13</sup> in 1896. However, only a few cases of bilateral simultaneous rupture of the quadriceps extension mechanism have been seen or reported. The first case report published was that by Steiner and Palmer<sup>12</sup> in 1949. Further reports by

Wetzler and Merkow<sup>15</sup>, Preston and Adicoff<sup>11</sup>, Dalal and Whittam<sup>5</sup> and Levy *et al.*<sup>7</sup> followed.

## Anatomy

The rectus femoris and the vastus lateralis, medialis and intermedius muscles coalesce to form the quadriceps extension mechanism. This common tendon cuff forms the front wall of the knee joint and covers all but the articular surface of the patella before becoming the infrapatellar tendon. This entire mechanism acts to extend and stabilize the knee joint and the patella is its weakest link. However, in cases of chronic debilitating diseases or excessive attritional degeneration of the adjacent tendon fibers, the musculotendinous components may be weakened to the point of rupturing under specific force.

The patellar tendon, ligament, and retinacula, formed from the vastus medialis and lateralis muscles, constitute the anterior fibrous capsule of the knee joint. The four bursae, with their relationship to the anterior fibrous capsule of the knee joint, are illustrated in Figure 1.

## Pathology

Under normal circumstances the patella is the weakest point in the quadriceps extension mechanism. However, in the chronically debilitated patients, the musculotendinous portion of the quadriceps extension mechanism is weaker and may tear under unusual stress (violent quadriceps contraction against a sudden load of the body weight on the flexed knee).

\*This case study is from the Cooper Medical Center, Camden, New Jersey.



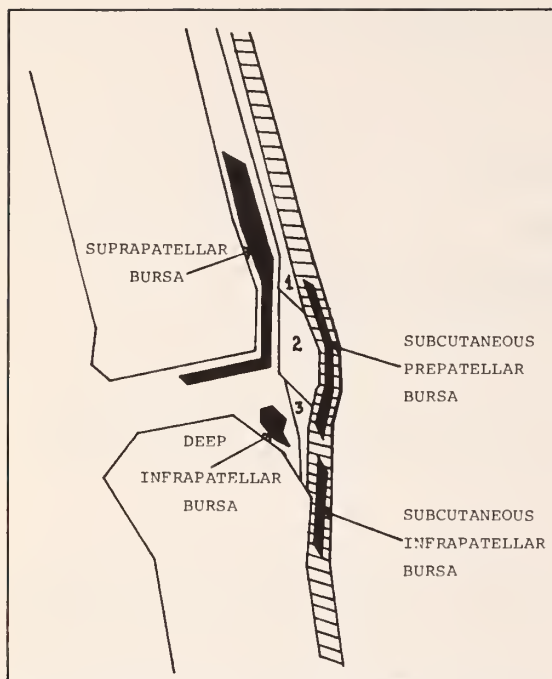


Figure 1—The four ventral bursae are labeled and shown in the mid-sagittal plan of the knee joint. 1. Quadriceps expansion formed by the rectus femoris and vastus lateralis, medialis and intermedius muscles. 2. Patella. 3. Infrapatellar tendon.

The usual history is that the patient stumbled on a step and fell with the knee in a partially flexed position while attempting to straighten himself out and prevent the fall.

Musculotendinous quadriceps tears have been reported in gout<sup>7</sup>, diabetes<sup>1</sup>, secondary hyperparathyroidism<sup>3</sup>, systemic lupus erythematosus<sup>14</sup> and chronic renal failure with acidosis<sup>10</sup>. Also, excessive use of steroids, such as in systematic lupus erythematosus, may contribute to this state. The common finding in all of these conditions are alerted and weakened tendon structures. The ruptures begin as minute tears in the degenerating tendons and extend under tension. In the case of gout<sup>7</sup> extensive fibrinoid necrosis and fibrin deposits have been seen histologically. In addition, there is marked synovial proliferation with the formation of villous processes infiltrated by lymphocytes, macrophages, plasma cells, and granulomas.

## Diagnosis

The diagnosis may be confirmed by knee

arthrography<sup>6</sup> which would show an abnormal tract of contrast agent dissecting from the suprapatellar bursa into the soft tissue anterior to the patella and downward to a level below the tibial plateau. However, in most cases the diagnosis is made by the patient's history and physical findings. These patients usually experience, for no apparent reason, a sudden collapse while walking and are not able to extend their legs or stand up after the fall<sup>7</sup>. The physical examination discloses diffuse anterior swelling of the knee joint, at times subcutaneous ecchymoses, a palpable defect above the patella with local joint tenderness and inability of the patient to extend the knee voluntarily.

## Case Report

A 64-year-old male fell forward on his knees as he was standing on a curb, waiting to cross the street. He could not get up nor extend his knees after the fall. The patient denied any history of trauma, chronic debilitating disease, or previous knee problems. Physical examination revealed no ecchymosis, pain, or swelling of the knee joints. There was only a definite bilateral depression palpable above both patellae and the patient could not extend his legs.

A diagnosis of bilateral simultaneous rupture of the quadriceps extensor mechanism was made and the patient was prepared for emergency surgery. The pre-operative evaluation was normal except for a hemoglobin and hematocrit of 10 and 30 respectively.

At surgery exposure was obtained through a transverse incision about three to four cm proximal to the superior edge of the patella. Complete transverse tear of the musculotendinous portion of the extensor mechanism was found about two cm proximal to the patella. The torn edges were debrided and reapproximated to the tendinous attachment of the patella using interrupted O braided Tevdek® figure-of-eight sutures. It was not necessary to drill holes into the patella since there was sufficient tendinous tissue for suturing proximal to the patella. Full length posterior plaster of paris splints were applied from the patient's toes to his mid-thigh region and secured by means of elastic bandages prior to termination of anesthesia.

Postoperatively, an extensive evaluation of the patient's anemia revealed it to be on the basis of G-6-PD and iron deficiency. He was treated with packed red cell transfusions, an oral iron and vitamin medication, and advised against taking any medications which are detrimental to those with G-6-PD deficiency. Ten days later, full-length cylinder casts extending from the ankles to mid thigh were applied and the patient was discharged from the hospital.

About five days after discharge the patient was re-admitted because of a dizzy spell and pain in his left thigh and leg. An EKG revealed a non-transmural antero-septal myocardial infarction which was substantiated with enzyme studies. The left leg and thigh swelling was felt to be due to phle-

bothrombosis and a lung scan was compatible with RUL and LLL pulmonary embolism. The patient was treated with intravenous antibiotics, heparin, bed rest, with the left leg elevated, and with hot compresses. He responded nicely to treatment and the left leg and thigh edema subsided completely. The patient was discharged thirty days later, at which time weight bearing and ambulation with a walker were progressing well.

## Discussion

Bilateral rupture of the quadriceps expansion mechanism usually occurs in an older patient population and has no sex predilection<sup>8</sup>. Normally the patella is the weakest link in the extension mechanism, thus, when the musculotendinous portion of that mechanism is torn, the physician should be alerted to the possibility of systemic causes for the weakness of that structure<sup>3</sup>. The differential diagnosis should include chronic anemia, diabetes, chronic renal failure, systemic lupus erythematosus, gout and secondary hyperparathyroidism. The mechanism of injury is a sudden, resisted contraction of the quadriceps muscle in an attempt to prevent a fall. The normal tendon does not rupture under stress as shown by McMaster<sup>9</sup>, except by direct trauma. The dehiscence occurs at the musculotendinous junction through the muscle belly or at its insertion. The rupture usually begins as minute tears in the degenerating tendons<sup>14</sup> whose capacity to heal is impaired.

A triad of a palpable and painful suprapatellar defect, swelling of the knee joint, and inability to extend the leg voluntarily should be sufficient to make the diagnosis.

The repair is made by reapproximating the torn proximal tendinous tissue to the distal structures or even to the patella itself by creating burr holes. All kinds of suture material have been used for this repair, such as catgut, silver wire, silk, fascia lata fibers and even kangaroo tendons<sup>4</sup>. More recently, monofilament or multifilament synthetic suture has been used because of its strength and inertness.

The results are much better if the diagnosis is made quickly and surgery performed before fibrosis of the proximal contracted segment of muscle occurs. Delay in surgery would make it more difficult to approximate the proximal

segment to the patella or its adjacent tissue and would create tension at the suture line.

The healing and convalescent period is usually three to six months during which time cylinder casting and later progressive ambulation with partial weight bearing is required prior to unassisted ambulation. In addition, treatment and correction of any systemic disease must be accomplished.

## Summary

1. Bilateral simultaneous rupture of the quadriceps expansion mechanism is a rare entity, less than ten cases having been reported in the literature.
2. If thought of, the diagnosis is usually easily made by a good history and physical examination.
3. The older patient population tends to be affected and there is no sex predilection.
4. A chronic systemic debilitating disease is usually present in such patients, as well as the use of steroids in isolated cases.
5. Treatment is surgical reconstruction of the quadriceps extension mechanism and the earlier the repair, the better are the long term results.
6. The rehabilitation is prolonged, usually requiring three to six months.

## References

1. Brotherton BJ, Ball J: Bilateral simultaneous rupture of the quadriceps tendons. *Br J Surg* 62:918-920, 1975.
2. Buttner A: Clinical aspects and evaluation of quadriceps tendon ruptures. *Beitr klin Chir* 179:247-272, 1950.
3. Cirincione RJ, Baker BE: Tendon ruptures with secondary hyperparathyroidism. *J Bone & Joint Surg* 57-A:852-853, 1975.
4. Conway FM: Rupture of the quadriceps tendon. *Am J Surg* 50:3-16, 1940.
5. Dalal VD, Whittam DE: Bilateral simultaneous rupture of the quadriceps tendons. *Br Med J* 2:1370, 1966.
6. Jelaso DV, Morris GA: Rupture of the quadriceps ten-

- don: Diagnosis by arthrography. *Diag Radiol* 116:621-622, 1975.
7. Levy M, Seelenfreund M, Maor P, Fried A, Lurie M: Bilateral spontaneous and simultaneous rupture of quadriceps tendons in gout. *J Bone Joint Surg (Br)* 53:510-513, 1971.
  8. McLaughlin HL, Francis KC: Operative repair of injuries to the quadriceps extensor mechanism. *Am J Surg* 91:651-653, 1956.
  9. McMaster PE: Tendon and muscle ruptures. Clinical and experimental studies on the causes and location of subcutaneous ruptures. *J Bone & Joint Surg* 15:705-722, 1933.
  10. Murphy KJ, McPhee Ian: Tears of major tendons in chronic acidosis with elastosis. *J Bone & Joint Surg* 47-A: 1253-1258, 1965.
  11. Preston FS, Adicoff A: Hyperparathyroidism with avulsion of three major tendons. *N Engl J Med* 266:968-971, 1962.
  12. Steiner CA, Palmer LJ: Simultaneous bilateral rupture of quadriceps tendon. *Am J Surg* 78:752-755, 1949.
  13. Walker J: Rupture of the quadriceps extensor femoris muscle and of its tendon above and below the patella. *Am J Med Sc* 3:638-649, 1896.
  14. Wener JA, Schein AJ: Simultaneous bilateral rupture of the patellar tendon and quadriceps expansions in systemic lupus erythematosus. *J Bone & Joint Surg* 56-A:823-824, 1974.
  15. Wetzler SH, Merkow W: Bilateral simultaneous and spontaneous rupture of the quadriceps tendon. *JAMA* 144:615-616, 1950.

423 Cooper Street, Camden

### Pediatric Briefs\*

**Adenovirus Type 3 Pneumonia Causing Lung Damage in Childhood.** Herbert, F.A. *et al.*: *Canad. Med Assoc J* 116:274 (1977).

Nineteen children ages 3 to 21 months were victims of an epidemic of adenovirus pneumonia. The pneumonia was severe in many of the children with signs of bronchiolar obstruction and atelectasis. However, none of the children needed ventilatory assistance and none died. When reevaluated 8 to 10 years later, 10 had abnormal x-rays and 7 had bronchiectasis.

*Comment:* Adenovirus is known to be able to cause severe necrotizing bronchiolitis and pneumonia as well as pertussis syndrome, classical bronchiolitis, and laryngotracheobronchitis. This agent may be the commonest cause of bronchiectasis. Severe pneumonia need not be bacterial; viral pneumonia need not be mild and "self-limited."

R.H.R.

**Successful Protection of Humans Exposed to Rabies Infection.** Bahmanyar, M. *et al.*: *JAMA* 236:2751 (1976).

A new rabies vaccine prepared from human diploid cells (rather than duck embryo) was given with antirabies serum to 45 persons severely bitten by rabid wolves and dogs. This combination was totally effective. Several patients were begun on therapy as long as 14 days after exposure with excellent results. The authors conclude that "... a major breakthrough has been achieved. ...". The human diploid vaccine is highly immunogenic and virtually without side effects.

*Comment:* This field trial of a new vaccine is very encouraging.

R.H.R.

\*Excerpts from CMDNJ Rutgers Medical School *Pediatric Newsletter* (Vol. 1, No. 8, June 1977), Richard H. Rapkin, M.D., Editor. Dr. Rapkin has given *The Journal* permission to reprint this material from time to time.



## Bioethics: Health Care Questions for a New Age

Russell L. McIntyre, Th.D.\*

The eminent social analyst and psychologist Rollo May has written recently:

We are living at a time when one age is dying and the new age is not yet born. . . . To live with sensitivity in this age of limbo requires courage. A choice confronts us. Shall we, as we feel our foundations shaking, withdraw in anxiety and panic. Frightened by the loss of our familiar mooring places, shall we become paralyzed and cover our inaction with apathy? If we do these things, we will have surrendered our chance to participate in the forming of the future. . . . Or shall we seize the courage necessary to preserve our sensitivity, awareness and responsibility in the face of radical change? Shall we consciously participate, on however small a scale, in the forming of the new society? (from *Courage to Create*)

The "new society" which May envisions, though long in coming, already has started to manifest itself in our experience. No one can point specifically and say "there it is!" But, all of us feel its birth pangs.

Movements to create change usually take one of two possible directions. The most radical is total social upheaval—revolution—which often allows for the creation of a social order more intolerable than the one which created the need for revolution. In such a process the identity of the oppressors changes, but oppression is still the *modus operandi*.

The calmer model for change is much like the incoming tide. Its moment-by-moment progress almost goes unnoticed, until at last there has been significant change.

The American model for change has been more like the latter. Indeed, the political structure of our society tends to permit major changes only every four or eight years, with the intervening period resulting in a quieter working out of the details of that change. In contrast, of course, are the democracies of Western Europe which can collapse and change with a simple "vote of no confidence" in the ruling party.

At the center of the most recent, and, incidentally, the most pervasive, decade of social change in America is the concern raised over the inequities in America's health care industry. While absolutely astounding changes have occurred in both the medical community's ability to deal with acute and chronic disease and the quality of needed services, serious questions are being raised with regard to the extent to which newly developed medical technologies are being employed to support life and the decisions that are being made about patient care. Four major factors are responsible for this change.

First, from the technicians' perspective, the most important aspect is the scientific developments of the technologies themselves. Advances in biomedical technology in the past ten years radically have changed the practice of medicine and the provision of health care. And hospitals generally have not been slow to adopt the latest methods, devices, theories, drugs, or technologies. This may be part of the problem, i.e., that there are differences of opinions about which therapy is most effective or which drug has fewer undesirable side effects. Time, research, and experimentation eventually will settle many of these issues but, until it does, ambiguities remain.

Second, from my perspective as an ethicist, equally as important as the technological advances are the dramatic social changes that have taken place in the United States in the past ten to fifteen years. Prior to the Kennedy years, America was still trying to stabilize herself after World War II. The Eisenhower years

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\*Dr. McIntyre is Director, Programs in Health Care Humanities, CMDNJ. Formerly a Fellow in Medical Ethics at Harvard Medical School, he is a bioethicist and currently serves all CMDNJ schools as a member of Dr. Bergen's staff.

were, to a large extent, stabilization years which allowed for business and industry to concentrate on growth and development, but also allowed for the inequities of the capitalistic system to become re-entrenched in the working mentality of "status quoism."

With Kennedy, the transformation began. But instead of dealing with America's pervasive social problems, the major impetus was given to the scientific community to develop a technological dream of reaching beyond planet earth. Science and technology were being combined, not to bring the "good life" here to those on earth, but to help us reach it somewhere else.

It was principally during the administration of Lyndon Johnson that America's second civil revolution began. Probably because of forces present not of his own choosing, national policies developed which allowed for major social changes to occur. Political "conservatives" suddenly saw the U.S. Constitution and Bill of Rights as the radical document it is. "The rights of man," John Kennedy had asserted in his inaugural address, "come not from the hands of the state, but from the hands of God." That "all men are created equal . . . endowed by their creator with certain unalienable rights," became the force of major Supreme Court decisions. And an ethical, legal, and social revolution was under way. Of all of the changes that have taken place in our society, this change in our conceptual realization of human or natural rights has been the most powerful in sensitizing us to the inequities of the system.

A third major factor is in the type of protection that American citizens are demanding from the institutions and systems which surround their lives. Beginning as a revolt against the rising cost of living, the consumer movement has affected every aspect of public responsibility and accountability. Consumer advocates like Ralph Nader, Common Cause, and the ACLU have arisen to force the public bearers of social responsibility into a recognition of how easily their social contract can—and does—become perverted for personal gains. In addition, the

concept of a "special prosecutor" has now been widely accepted as a "necessary evil" to deal with corruption, even in the highest of offices, e.g., the Presidency of the United States.

These three major developments all have affected the distribution of health care services in the United States. It is, perhaps, most obvious with the advancements of biomedical technology. The civil rights movement and the consumer movement also have placed tremendous challenges on the health care system, or "non-system" as it sometimes has been called. The demand for equal access to health care services and facilities has been extended into the concept of "national health insurance" programs and proposals for a "national health service corps." Various programs, especially "Medicare" and "Medicaid" have contributed to the growing understanding of health care as a "right" for all Americans.

Finally, a fourth development is currently cresting on the horizon, namely the malpractice crisis. Many, unfortunately, fail to see the malpractice issue as an extension of the "civil rights" and "consumerism" movements, but it is, in fact, just that—an extension of the basic "rights" notion of man coupled with the need to be protected against misuse by the "system" of health care. There is no question but that inappropriate things have been done. No one recognizes this any more painfully than the sensitive clinician. What to do about these problems is often much more than an individual matter. It might also mean a change in hospital policy, confronting the practices of colleagues, or "bucking" the politics of the system.

But major changes are, in fact, occurring. Sensitivities today are considerably different than they were fifteen years ago. Recognition of "patients' rights" and the professions' responsibilities are articulated much more clearly today than they ever have been. And the ethical, legal, and social responsibilities of all health care providers are recognized and respected more universally.

In point of fact, my role as a "bioethicist" is quite new. Before 1970 there were no such

individuals. And there are still frightfully few "in the field." Indeed, the term "bioethics" has not yet found its way into the latest medical dictionaries even though several medical schools have recognized the importance of introducing students to the issues bioethicists are raising.

The field of bioethics is one of the most exciting fields to develop in health education. Its scope is as wide as biomedical research; its depth includes the most basic questions of human life and meaning; and into its purview come all members of the health "team."

Ethics is both the study of human action and the search for the values which underlie those actions. It is also the search for normative judgments by which we can qualitatively interpret the meaningfulness of human life. Bioethics begins with questions about the appropriate use to which biomedical technologies are applied, but very quickly gets to the deeper questions of life, namely the philosophical questions about life's purpose, meaning, direction, and whether or not social life can be improved through specific proposals for change.

The questions are deep questions and, perhaps, to the non-philosophically inclined, seem too vague and abstract to answer concretely. Such a typical question might include: "What is the nature of human freedom and autonomy?" Very vague and difficult to answer in the abstract. But, if the question of human freedom is applied to patient's rights, and the question of autonomy to informed consent, suddenly these abstract questions become extremely relevant for the provision of health care.

Another example might be the question: "Are human rights naturally endowed or only politically conferred?" What about the right to bear children? How about as many children as we want? Basically our society has affirmed the "natural" rights of procreation. But, will that also hold for our future? In 1973 the "President's Commission on Population Growth and the American Future" projected that unless something drastic is done to curtail population growth in the United States, by the year 2073

we could have a population of one billion living within our continental limits—about a five-fold growth of our current population. We are aware of the forced sterilization program in India. What will be the direction of our society in the future? How much authority should our government have in regulating population growth? Who should decide who has the "right" to reproduce? We realize, of course, that even if everyone alive today agreed to go to "zero population growth" (i.e., only reproduce yourself) that it would take seventy years before the population would stabilize.

More exciting, perhaps, than these "philosophical" questions is a recognition that it is the availability of the technologies themselves that raise the ethical, legal and social questions. The questions here involve defining both the appropriate and inappropriate uses for the technology in question. The technologies can be divided into at least six basic categories.

*1. Technologies of Population Control*—Questions here would revolve around the moral and ethical justifications appropriate to the methods of population control, namely contraception, abortion, and sterilization. The questions might include, among others: Once conceived, is there any "right" to be born? Who should decide? Is a fetus a human being? Is it or should it be protectable in the same way that a child born alive is protectable under the law? What about congenitally deformed infants? Is there a social mandate to keep them alive by employing all heroics possible regardless of the minimum quality of life they would enjoy? Is there any moral or ethical difference in letting die or actively terminating? Should there be a law to protect every product of human conception? Including those very seriously deformed or genetically damaged?

*2. Technologies of Genetic Control*—The basic question of human genetics involves the extent to which we are willing to substitute the design and engineering of future human beings (and society) for the evolutionary natural selection process. It may include genetic engineering, cloning, therapy on defective genes, artificial insemination for desirable physical and/or mental characteristics, *in vitro* fertilization,



pre-natal diagnosis and counseling, and restricted procreation rights for those with genetic anomalies. The field also includes the possibilities and dangers for "Recombinant DNA Research" which technologically combines genes from nonrelated species into the creation of new forms of "life."

*3. Technologies of Behavior Control and Modification*—It is sometimes recognized that the basic purpose of psychiatry is often different from that of medicine, namely that, while medicine functions by the guideline of what is in the patient's best interest, psychiatry functions very often by the guidelines of what is in the society's best interest. The questions here would involve the mental patient's "right" to treatment, the appropriateness of institutionalization for "mental" illness, the appropriate uses of drugs, psychosurgery, psychiatry, electroshock, and so on, for purposes of behavior modification or control. There are significantly different dimensions to the questions of informed consent and proxy consent when dealing with mental illness. If it is true, as Rollo May has insisted, that psychiatrists are moralists and teachers, to what extent is it appropriate to substitute society's will for the will of the individual through the techniques of thought control and redesigning behavior patterns?

*4. Technologies of Control over Death and Dying*—This is one of the most widely discussed areas in the entire field of medical ethics, mainly because of the sensitivities surrounding such widely publicized cases as Karen Ann Quinlan. Because of major advances in biomedical technologies, medical science is able to keep the body functioning mechanically after many of the body's own systems have failed. The questions here involve the making of "quality of life" decisions, when is a person dead, and to what extent should we keep a person on mechanical support systems when it is unclear whether we are prolonging life or only postponing death? Other questions might be: Is the physician ever morally obligated to assist the person in his dying? For example, a person in the final stages of a terminal illness in which excruciating pain cannot be relieved

except by megadoses of narcotics which, beyond a certain level, become life-threatening because of their ability to depress respiratory and cardiac function. Is this euthanasia?

*5. Technologies for Medical Experimentation and Research on Human Subjects*—It is obvious to most people that in order for medical science to advance, research on human subjects must occur at some point, whether it be for testing a new drug or perfecting a new surgical technique. The results gained in animal research do not guarantee the same clinical results in humans. Therefore, as is certainly the case, regulations (federal, state and institutional) must guide biomedical experimentation on human subjects. The research must be conducted within certain ethically defined limits stressing informed consent and the right of the research subject to withdraw from the experiment at any time. But, who is qualified to give consent? Can truly "informed" consent ever be given, especially on a new drug whose side effects and therapeutic benefit have not yet been established. Can children give consent? Or can their parents give "proxy" consent? What if it is for a non-therapeutic experiment? How about prisoners and/or mental patients? Can consent in these areas ever be free from coercion? And would it ever be appropriate (ethical?) to use a human subject for research purposes against his will? What if his disease or condition posed a tremendous threat to the survival of mankind or he had an extremely contagious disease? Can the benefit to society ever be used to justify compelling persons to be used in research? Do patients admitted to teaching hospitals implicitly consent to being used both for teaching and research?

*6. Miscellaneous Matters or Other Considerations Affecting Health Care Delivery*—Ethical questions raised here span an almost unbelievable spectrum from "truthtelling" to the role of government in health care policy formation. Is there a right to health or to health care in this society (two very different questions)? Does a physician (or hospital) have the "right" to refuse needed (or emergency) medical services to a person who cannot pay for them? We realize, of course, that many poor people do

not qualify for public assistance programs. What are the rights and responsibilities of the physician-patient relationship? How can a patient's confidentiality and right to privacy be protected as more and more medical information is being stored in computers with access to that information being available to more and more people? What are the physician's ethical obligations to "keep up" with the latest advances in biomedicine? How can his continued competence be measured and evaluated? Should relicensing exams be required periodically? Should continuing education be required for recertification? How can current "team" approaches to health care delivery be structured to assure a sharing of both responsibility and power by all health care persons involved? How can the patient best participate in the health decisions made about his or her life? If the patient is unable to participate (incompetent or comatose), how can the family best participate? Who should decide medico-moral problems—the physician, the patient, the family, a patient-advocate, a hospital "ethics" committee, a hospital administrator, some combination of these, or the courts?

It should be obvious, even to those who have never had (or been involved in) a major medical crisis, that these all are important questions. Every question asks about the underlying

"values" with which we approach the questions of life, death, and the dilemmas that occur between those two points. In an important way, we have been too successful too rapidly, i.e., we have perfected the technologies which surround us before we have fully explored and clarified the appropriate and the inappropriate uses to which that technology might be applied. This is not at all to suggest that the technologies ought to be rejected. Rather, it is to suggest that the potential benefits and problems of the technologies ought to be brought into the public forum before becoming either matters of accepted social policy or medical policy.

We are at the threshold of an age in which it will become increasingly possible to design a great deal of both that which surrounds life, such as ecology, and "life" itself, through genetic engineering and behavior control. Whether or not this is the "new age" which Rollo May envisions, it is important to heed his plea to "seize the courage necessary to preserve our sensitivity, awareness, and responsibility in the face of radical change." Biomedical ethics is one important step in the attempt to raise the most essential questions about human life—its purpose, its meaning, its direction—and of the values that underlie life which make it truly "human."

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Riboflavin (B-2) . . . . . 2 mg.  
Pyridoxine HCL (B-6) . . . . . 10 mg.

**DOSE:** 1 to 5 tablets daily.  
**AVAILABLE:** Bottles of 100, 500, 1000.

**LIPO-NICIN/250 mg.**  
Each yellow tablet contains:  
Nicotinic Acid . . . . . 250 mg.  
Niacinamide . . . . . 75 mg.  
Ascorbic Acid . . . . . 150 mg.  
Thiamine HCL (B-1) . . . . . 25 mg.  
Riboflavin (B-2) . . . . . 2 mg.  
Pyridoxine HCL (B-6) . . . . . 10 mg.

**DOSE:** 1 to 3 tablets daily.  
**AVAILABLE:** Bottles of 100, 500, 1000.

### GRADUAL RELEASE

**LIPO-NICIN/300 mg.**  
Each time-release capsule contains:  
Nicotinic Acid . . . . . 300 mg.  
Ascorbic Acid . . . . . 150 mg.  
Thiamine HCL (B-1) . . . . . 25 mg.  
Riboflavin (B-2) . . . . . 2 mg.  
Pyridoxine HCL (B-6) . . . . . 10 mg.  
In a special base of prolonged therapeutic effect.

**DOSE:** 1 to 3 tablets daily.  
**AVAILABLE:** Bottles of 100, 500.

**Indications:** For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPONICIN 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient. **Side Effects:** Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur. **Contraindications:** Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.



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## Improved Health in Newark: An End to Perceptions of the Past

The theme statement for a recent, city-sponsored symposium on health care in Newark had the sound of urgency about it that characterizes much of the rhetoric about Newark and urban places like it. The statement suggested crisis, the need for action, now. It concerned the "flight" of physicians, "bridging gaps," and "viable alternatives."

It was the rhetoric of government planners on the move, people anxious to demonstrate their compassion and devoted to polishing their skills, promoting their jobs and doing, in general, what they are trained and hired to do. As a person charged with considerable planning responsibilities in Newark for a number of years myself, I understand the language of crisis. We used it to call attention to problems, our efforts to confront if not solve them, and to attract federal dollars.

Indeed, the present stereotype of Newark as a model of urban decay resulted not only from its very real problems, underscored by the traumatic disorders of 1967, but also in part from national policy in the 1960s which required cities to dramatize their worst conditions in order to compete successfully for federal aid. An additional factor was the overheated political and racial rhetoric of the day, particularly in Newark, which was in the process of shifting from white to black political control.

If we accept that what we tend to believe about Newark today results in part from a set of circumstances not likely to be repeated again soon, we are free to reconsider the stereotype, reinterpret data with an open mind, and find our way to more objective analysis and decision-making.

The Urban Health Institute has been conducting hospital planning and testing a model health education program in Newark for several years. As a result, we have taken fresh looks at its data. The data which are available suggest a city not unlike many others. The common

conditions include a declining population, eroding tax base, and a relatively high percentage of persons with incomes below the poverty level. However, the percentage of substandard housing in Newark, a frequently used measure of decay, was reduced from 1960 to 1970 and the reduction has continued in the 1970s.

In terms of personal health, the statistics for Newark show marked improvement and in some cases indicate conditions better than the rest of the tri-county area of Essex, Union, and Hudson. They suggest a normalization which may be closer to the truth about Newark in the 1970s than perceptions established in the previous decade.

The following brief Institute analysis of Newark's health data may contribute some perspective.

Newark health data reflect the relative youth and poverty of its population. Death rates from cancer, for example, are substantially lower in Newark than the rest of the State. This is also true of death rates from cerebrovascular disease. Death rates from heart disease match those of the tri-county area. The youth of the population is undoubtedly a factor in these rates, but they are positive, nonetheless.

Newark's infant mortality rates and neonatal mortality rates have tended to be higher than the statewide rates. However, there have been indications that the neonatal and infant death rates in Newark are tending to approximate more closely the statewide rates and that the difference between the rates among the white and non-white populations, also widely publicized, may not only be equalizing, but reversing itself.

For example, in 1974, the last year for which official figures were available in time for this analysis, the infant mortality among the majority black population in Newark was lower than the rate among whites. The rate among blacks was reported as 20.2 deaths per 1,000 births as compared to 21.6 deaths for whites in Newark and 25.5 deaths for blacks in the tri-county area, 26.9 deaths for blacks in the rest of Essex and 39.3 deaths for blacks in Hudson. The neonatal mortality rate for Newark as a whole in 1974 was reported at 11.0 deaths per 1,000 births, lower than the overall tri-county rate of 13.4 deaths. Among blacks in Newark the rate was reported at 9.4 deaths, the lowest of any group, black or white, in the tri-county area and lower than all whites in New Jersey as a whole.

Conversely, tuberculosis and venereal disease rates in Newark, while improving, are still substantially higher than

in the State as a whole.

The tuberculosis morbidity rate declined from 99.5 cases per 100,000 population in 1970 to 69.0 cases per 100,000 population in 1974 -- a decrease of over 30 percent in the prevalence rate in Newark. This was only a slightly greater improvement than the statewide improvement of almost 29 percent decrease in the rate.

The prevalence rate of syphilis per 100,000 population in Newark remains high at 169.1 cases per 100,000 population. However, the 1974 rate was less than five times the statewide rate, as compared with the 1972 rate which was almost six times the statewide rate. Similarly, with regard to gonorrhea, Newark's high prevalence rate of 1,333.4 cases per 100,000 population in 1974 was just over six times the statewide rate compared with its 1970 rate which exceeded the statewide rate by almost ten times. However, venereal disease rates are among those most affected by uneven reporting and any analysis of them must be treated with caution.

It may be that some of the improvement in Newark results from reporting inaccuracies or from mistakes in processing the data among agencies. The State Health Department is among those surprised by the data. On the other hand, it may be that all the time, energy, skill and money that thousands of persons and dozens of agencies have invested in helping Newark have begun to produce positive results.

In any case, it calls into question many assumptions about Newark. There may well have been a "flight" of physicians from the city, but there are no hard statistics to prove it. The city's health planners are trying to develop some, however, they may find that the "flight" simply matches the steady decline in Newark's overall population.

The important thing about any such "flight" is that it presumably opens a "gap" between "need" and availability of service. The conventional wisdom suggests such a "gap" indeed exists. But does it? As planners and evaluators, we would be better able to judge if someone would define "gap" and "need," not to mention "availability." Arguments about how best to define and measure such things thrive in health planning circles and remain largely unresolved.

In considering any "gap," it is worth remembering that while the ratio of people seeking service to private physician hours in Newark is unknown, the utilization of health centers and hospitals is known. Newark has some of the finest hospitals in the state, Saint Michael's and Beth Israel, are examples. It has a medical school

and a new university hospital under construction. It has a significant number of Medicaid-related practices and facilities, some good, others not so good. It has a series of neighborhood health centers, with others still to come, which would be the envy of cities twice Newark's size. It has, in its Medicaid Waiver project, a 54 million dollar demonstration on behalf of the medically indigent, larger than any undertaken in the nation. With all this, the health centers in Newark are far from crowded and the hospitals run at occupancies of between 70 and 80 percent, which is compatible with state and national averages, hardly indicative of any pressure for service.

Is there a "gap" then, one which requires "viable alternatives?" Possibly. But it would be well to define better where it exists, who is affected by it and what needs to be done about it. Newarkers waiting to see a doctor doesn't prove much. Virtually all Americans wait to see a doctor, even in the richest of suburbs. Newarkers "forced" to use hospital emergency rooms and clinics doesn't prove much either. Emergency rooms are misused in the suburbs as well. It has more to do with the style of private practice than with anything sinister. Doctors don't like to work evenings and don't make house calls. That's as true in Princeton as it is in Newark. In fact, the use of emergency rooms as family physician in both places, particularly in the evenings, is quite similar. In Newark, people are short of money and in Princeton, short of time.

My own view is that Newark faces very real and serious problems, in health and in a wide variety of other things that help determine quality of life. So do many other places. Newark is not, however, at the edge of disaster. It is simply at another point on a continuum; identifying problems, confronting them, solving some of them and, of course, leaving the new problems produced by old solutions to those who follow.

My purpose is to help us look not at Newark through the eyes of the sixties but of the seventies and eighties. If we do that, we might agree it is time to find out more clearly how much the many programs and initiatives now underway

can contribute to the well-being of Newark before succumbing once again to the vocabulary of crisis.

The Newark health care system has changed significantly and for the better. So has the health of its residents. It may be small comfort to those who still suffer disease without adequate care or to those who must accept service

offered without dignity, but improvement in Newark is a fact. It is time to evaluate the city's positive health trends. What has worked well? What hasn't? Why? It is time to insure that new activities and resources are keyed not to the past, but to the needs of people today.

Donald Malafronte, Director  
Urban Health Institute

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# NEW JERSEY DOCTORS' NOTEBOOK

## Trustees' Minutes

October 16, 1977

A regular meeting of the Board of Trustees was held on Sunday, October 16, 1977, at the Executive Offices, Trenton. Detailed minutes are on file with the secretary of your county medical society. A summary of significant actions follows:

*Medical Care Study* . . . Referred to the Council on Medical Services Dr. Begen's suggestion that a study be made to determine the distribution of medical care in the State of New Jersey—to identify any lack of proper distribution, to define such lack, and to recommend to the Board of Trustees the manner in which any deficiencies can be rectified.

*National Health Insurance Hearings* . . . Received a report from the Executive Director that Drs. Benz and Watson participated in the first National Health Insurance Hearing held in Newark on October 13, and that Drs. Krosnick and O'Regan would represent MSNJ and NJFHCE, respectively, at the second hearing in Trenton on October 19.

*New Headquarters Facility* . . . Authorized the expenditure of up to \$1,500 for an architectural study of the feasibility of acquiring a building in Lawrence Township, formerly occupied by Educational Testing Services, as a new headquarters facility to house MSNJ, the Insurance Exchange, the New Jersey Foundation, and possibly, the Academy of Medicine.

*CMDNJ* . . . Received as informative a report from Dr. Bergen, President, CMDNJ, which discussed the following items:

1. CMDNJ is opposing Assembly Bill 3258 which would direct CMDNJ to award a Doctor of Science in Dentistry degree to a candidate who, for reasons of visual difficulties, was forced to withdraw prior to completion of course requirements, on the grounds that it is an invasion of academic freedom and takes from the Board of Higher Education the very powers granted by the Legislature in 1966, and that since the student has not fulfilled the require-

ment for graduation to confer such a degree would endanger the institution's accreditation.

2. CMDNJ's proposed budget for 1978-1979 is \$132 million which would support six academic units, two hospitals, and two community mental health centers.

3. CMDNJ's Deans are developing a position paper indicating the eventual enrollments, with initial attention directed toward the annual number of physician graduates.

4. Concerning the issue of temporary licensure and countersigning of residents' orders, there is some small evidence of a developing change in the Board of Medical Examiners' attitude and a realization by some of the members of the inadvisability of enforcing the countersignature, 48-hour rule.

5. CMDNJ's educational effort in behalf of the New Jersey Medical Education Facilities Bond Act of 1977—A-3352.

6. CMDNJ's Foundation has announced that the proceeds of its endowment exceed \$10 million.

7. The issue of foreign medical graduates, both foreign nationals and United States citizens attending foreign medical schools.

*New Jersey Hospital Association* . . . Received as informative a report from Mr. Jack Owen, President, NJHA, which discussed the following:

1. NJHA litigation to challenge the Department of Health and the Health Care Administration Board on its adoption of a rule requiring hospitals to submit charge data by cost center.

2. Certificate of Need for radiation therapy—the issue is whether the Health Care Administration Board and the Department of Health have authority to regulate physicians' income, since the law excludes the private practice of medicine. The Health Care Administration Board deleted the requirements that hospitals must submit information on total charges in the department of radiology and that physicians must contract to provide the service, but directed that hospitals must report the total remuneration paid to specialists.

3. Compliance form under the Rehabilitation Act of 1973—NJHA has been advising hospitals not to sign the form on the basis that they may waive their rights to challenge future regulations. HEW counsel advises hospitals to sign and attach a letter which indicates they are not waiving such rights.

4. Hospital Association Health Plan, administered by Prudential—eight hospitals are participating; the schedule of payments is the same as those for Blue Shield.

*MSNJ Student Association* . . . Approved the following recommendation concerning the

Medical Society of New Jersey Student Association, whose membership presently is 35:

That the present student members be placed on the overall membership mailing list of the Medical Society of New Jersey so that they may receive *The Journal* and the *Membership Newsletter*.

*Medicaid Payment for Abortion* . . . Approved the following recommendation (as amended by the Board) from the Committee on Medicaid:

That the Medical Society of New Jersey reaffirm its position that abortion services be considered by all third party payers as compensable services.

. . . Voted to instruct MSNJ's AMA Delegates to introduce a resolution in support of that recommendation at the 1977 AMA Interim Meeting in Chicago in December. Copies of the resolution, with a covering letter, should be sent to New Jersey Congressional Representatives, the Governor of New Jersey, the Commissioner of the Department of Human Services, the New Jersey Division of Medical Assistance and Health Services, and MSNJ's Council on Public Relations.

*MSP Coverage for Surgical Assistants* . . . Approved the following recommendation from the Council on Medical Services:

That the Medical Society of New Jersey support the incorporation of the payment of assisting surgical fees into Blue Shield's basic contract; and if this is impossible, MSNJ support the implementation of some method or methods to cover this cost for the patient's benefit.

*Note:* MSP had developed a Rider (at an additional premium) to cover assisting surgeon fees, which was disapproved by the Commissioner of Insurance.

*Weight Control Centers* . . . Approved the following resolution, a substitute for the one proposed by the Council on Medical Services, concerning "certificate of need" for weight control centers:

That a communication be sent to the New Jersey State Department of Health, expressing the concern of MSNJ that, by the requirement of a certificate of need (for the opening of a weight control center), the Department of Health is giving credence to free-standing agencies, without control.

*Health Care Delivery Systems* . . . Approved the following recommendation from the Council on Medical Services:

Recognizing that the delivery of health care in New Jersey has many nuances, and on the premise that (1) freedom of choice of physicians is a desire of many patients; (2) the private practice of medicine and its resulting patient-physician relationship is a desire of both patient and physicians; and (3) the prepaid concept, including preventive care, is attractive to many elements of society and is being encouraged by government, the Council recommends:

That, in addition to the already established modes of practice, those physicians who so desire be encouraged to form IPA/HMO types of organizations, with the marketing and promotion of such organizations left to those best qualified to undertake them.

*Note:* The council encourages a multiplicity of health care delivery systems, realizing that each practitioner should choose the types of practice that make it possible for him to serve patients in a setting conducive to the mutual well-being of patient and physician.

*Medical Necessity Program (Blue Shield)* . . . Approved the following recommendation from the Council on Medical Services as amended by the Board:

That the Board of Trustees of MSNJ accept the concepts

(1) That in the promotion of quality care, the removal from the procedure code of items which have been determined locally and nationally to be obsolete be encouraged; and

(2) That payment not be categorically denied, but, after appropriate and timely notification of the profession, be made only upon submission of a report satisfactorily establishing medical justification.

*Emergency Medical Care* . . . Approved the following recommendation from the Committee on Emergency Medical Care:

That the Board of Trustees approve the "State of New Jersey Plan for Emergency Mass Casualty Care" and its presentation at a conference on November 16 to which invitations will be extended to the following:

Hospital Emergency Department Physicians  
Hospital Administrators  
Emergency Department Nurses' Association Members  
New Jersey State First Aid Council Members  
Municipal and County Civil Defense and Disaster Control Directors  
Members of American College of Emergency Physicians, New Jersey Chapter  
County and New Jersey Fire Chiefs' Associations Members  
County and New Jersey Police Chiefs' Associations Members  
County Emergency Medical Services Councils Members

*Council on Public Relations* . . . Approved the following as continuing projects of the Council on Public Relations for 1977-1978:



(a) Publication and distribution of the *Membership Newsletter*, and a *Periodic Newsletter* to cooperating agencies/individuals, as required.

(b) Preparation and publication of special news releases as required in furtherance of the Society's activities, including the eye health screening program, the annual meeting, child safety week, and selected official programs.

(c) Bestowal of Golden Merit Award.

(d) Press releases and information center at annual meeting.

(e) Orientation programs for new members under sponsorship of component societies.

(f) Encouragement of statewide emergency medical care coverage.

In relation to the above item, the following recommendation, as amended by the Board, was approved:

That the Board of Trustees empower the Council on Public Relations to define and publicize "What is an emergency?" for the lay public.

(g) Voluntary blood donations.

(h) Radio broadcasts under auspices of component medical societies.

(j) Medical TV programs.

(k) Diabetes Detection Month.

(l) Placement Service.

*Professional Liability* . . . Directed that a communication be directed to the Commissioner of Insurance urging approval of a rate structure for the State Reinsurance Authority, under which some 3,200 New Jersey physicians are insured.

*Note:* On July 27, the Federal Insurance Company (administrator for the State Reinsurance Authority) filed a request with the Department of Insurance for an overall increase in professional liability rates of 41.4 percent, to affect policies which are renewable November 1. A public hearing was held on August 5, but no action has been taken by the Commissioner.

*AHA Committee on Regulatory Process* . . . Agreed to Dr. Madara's request for input from the Board on reaction scores on a questionnaire from the American Hospital Association setting forth regulation categories and suggested regulation recommendations.

*Social Security Numbers To Identify Medicaid Providers* . . . Directed that the AMA Delegates

introduce a resolution at the upcoming AMA Interim Meeting in December seeking reversal of the HEW position (via regulation) of requiring a physician's social security number as his Individual Medicaid Practitioner number (IMP) for the Medicaid fiscal agent, Prudential Insurance Company.

*Note:* In a communication to the Bergen County member physician concerning this matter Mr. Maressa (Executive Director) noted that a physician's medical license number could be used for such identification purposes. He also pointed out that Individual Medicaid Practitioner identification numbers may well jeopardize the corporate standing of physicians practicing via professional service corporations.

*Local HSA and NHI Problem Areas* . . . Instructed Marvin Solomon, M.D., President of the Cumberland County Medical Society to present to the Board a written report outlining the specific problems he is experiencing in South Jersey in dealing with the Hospital Service Administration and with national health insurance, and his suggestions for remedying such.

## Report from the Foundation

Daniel J. O'Regan, M.D., Medical Director

The Foundation extends to all who read these lines its best wishes for the holiday season, and a New Year free from strife. This was written before the November elections, so we can't say who will be waiting for Santa when he climbs down the chimney at Morven. Let's hope he leaves something that will sweeten the relationships between physicians and the State government. The year 1977 was an eventful one for us. The presence of PSROs, HSAs, and HMOs attracted the attention of our colleagues throughout the State. This has resulted in more physician awareness of the forces at work, and 1978 should produce more interest, as activities "heat up" even more. Some form of National Health Insurance legislation is sure to surface, and will stimulate more reaction than the Concorde at Kennedy Airport. The decibel count may be high, but the speed will be less than supersonic. Keep your cool, but keep yourself informed, and don't forget your patients. They will listen to you, and there is no better public relations medium.

## Membership Directory 1978-1979

Arrangements for the 1978-1979 *Membership Directory* have been concluded with Mercury Group Publications, a unit of the International Medical News Group, publishers of six national medical specialty news bulletins. Publication date has been set for September 1978.

The Mercury Group assisted MSNJ in the production and publication of the current *Directory*, and has completed an extensive study of our requirements, directed toward expediting the information-gathering process. Several new techniques (the results of which will be evaluated) are being introduced to improve the accuracy and speed of responses from members concerning their individual listings.

During this month a random group of 200 members will be contacted to test a telephone survey program. Two different procedures will be tried to determine which method is most productive and efficient for you as the member and for your association as the publisher. Complete instructions will be mailed to those members selected to participate. The survey methods are designed to encourage fast response and will not require more than the time needed to review and update the biographical listing in the 1967-1977 *Directory*.

A different procedure will be employed also to obtain hospital information. Hospitals will receive questionnaires which follow a standard format, designed to be used in conjunction with hospital personnel directories. Complete instructions will be included for completion of the questionnaires.

We emphasize the need for your *prompt cooperation* in supplying complete and accurate information and thus helping us in our efforts to contain the ever-increasing cost of producing our *Directory*.

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## Therapeutic Drug Information Center\*

### 1. Is there a known drug-drug interaction between propranolol and antacids?

Several studies have shown that aluminum hydroxide-containing antacids significantly decrease the bioavailability of a number of drugs including chlorpromazine (Thorazine®), isoniazide, quinine, tetracycline and digoxin.<sup>1-3</sup> Several proposed mechanisms by which antacids may decrease bioavailability include alteration of gastric pH, precipitation of drugs, interference with dissolution, adsorption of drugs to antacids, chelation, and delayed gastric emptying time.

Studies concerning propranolol (Inderal®) show that there is inter-individual variation in the absorption of this drug and that food may enhance its absorption.<sup>4</sup> Because of the widespread use of propranolol and the widespread use of products containing aluminum-hydroxide gel, and the possibility of concurrent use, Dobbs, *et al.*<sup>5</sup> conducted a study to evaluate the effects of aluminum-hydroxide gel on the bioavailability of orally administered propranolol. Five healthy patients, each acting as their control in a simple cross-over study, received either 80 mg of propranolol alone or in combination with 30 ml of aluminum-hydroxide gel. Concurrent administration of the antacid gel resulted in a decrease in bioavailability of propranolol in four of the five subjects. The mean decrease in maximum propranolol plasma concentration was 57 percent. The area under the plasma concentration time curve was decreased by 58 percent. Based on the above preliminary data, there is a suggestion that a significant drug-drug interaction may occur between propranolol and antacid gels. This interaction most likely can be prevented by spacing the doses of propranolol and antacid by several hours; or if they must be given concurrently, a larger dose of propranolol may be needed.

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\*The Schwartz Inter-National Pharmaceutic and Therapeutic Drug Information Center of the Brooklyn College of Pharmacy, Long Island University, compiles the information contained in this column each month. The Center serves as a source of intelligence on therapeutic and pharmacologic information not readily available to physicians, at no charge to them, and provides this information with minimal time involvement. It is staffed by trained pharmacists; Jack M. Rosenberg, Pharm. D., Associate Professor and Chairman, Division of Clinical Pharmacy, Brooklyn College of Pharmacy, is Director and Walter Modell, M.D., Emeritus Professor of Pharmacology at Cornell University Medical College, is pharmacologist consultant. The service is available Monday through Friday from 9 a.m. to 4:30 p.m.—telephone (212) 622-8989 or 303-2735. The following are questions and answers handled by the Center recently.

This month's column was prepared by J. M. Rosenberg, M.S., Pharm. D., M. K. Raina, M. Pharm., Ph.D., P. Sangkachand, B.S., Alan Bakst, Pharm. D., Doris Lau, B.S., Brooklyn College of Pharmacy, LIU.

## References

<sup>1</sup>Hansten P: *Drug Interactions*. 3rd Edition. Philadelphia, Lea & Febiger, 1975, pp 18, 180, 199.

<sup>2</sup>Hurwitz A, *et al*: Effects of antacids on gastric emptying. *Gastroenterol* 71:268-273, 1976.

<sup>3</sup>Dobbs JH, *et al*: Effects of aluminum hydroxide on the absorption of propranolol. *Curr Ther Res* 21:887-891, 1977.

<sup>4</sup>Melander A, *et al*: Enhancement of the bioavailability of propranolol and metoprolol by food. *Clin Pharmacol Ther* 22:108-112, 1977.

## 2. What is the value of antacid therapy in relieving pain and healing peptic ulcer?

Antacid administration remains the mainstay of the medical management of peptic ulcer. This usage is based on the assumption that neutralization of acid and deactivation of pepsin would result in alleviation of ulcer pain and acceleration of ulcer healing. It is surprising that hardly any well-controlled studies exist to support this assumption, and the results of recent studies are conflicting.<sup>1-4</sup>

Peterson, *et al*<sup>1</sup> conducted a four-week, double-blind clinical trial on 74 ambulatory patients, who had endoscopically proved duodenal ulcers, to determine whether a large-dose antacid regimen is effective in promoting healing of duodenal ulcers. The patients were divided into two groups. One group (36 patients) received (30 ml, seven times a day) liquid antacid containing magnesium-aluminum hydroxide (identical to Mylanta II). The other group (38 patients) received an inert placebo. The results indicated that the ulcers healed completely in 28 of the 36 antacid-treated patients as compared to 17 of the 38 placebo-treated patients, a statistically significant difference. However, the antacid regimen was not found more effective than placebo in relieving ulcer symptoms. Except for mild diarrhea, no significant side effects were noted in the antacid-treated group. The authors concluded that a high-dose antacid regimen hastens the healing of duodenal ulcer.

Sturdevant, *et al*,<sup>2</sup> in a double-blind, controlled randomized trial in 12 hospitalized male patients with duodenal ulcer, showed no significant differences between placebo and antacid (with buffering capacities similar to Gelusil M<sup>®</sup>, Riopan<sup>®</sup>, Amphogel<sup>®</sup>, A.M.T.) in time of onset, degree, or duration of ulcer pain relief. The results didn't necessarily prove that antacids have no effect on duodenal ulcer pain but may indicate that factors other than acid neutralization are involved in relief of ulcer pain.

Butler and Gersh<sup>3</sup> studied 28 hospitalized patients with endoscopically proved gastric ulcers. Fifteen of the patients received one ounce of an antacid containing aluminum hydroxide, magnesium hydroxide, and simethicone every two hours. Nineteen patients received one ounce of an identical placebo every two hours. The medication or placebo was administered while the patients were awake. In addition to weekly questioning, endoscopy was performed in each patient at the end of the three-week trial period. The ulcers healed satisfactorily in ten patients in the placebo group and eleven patients in the antacid group.

All patients were free of pain during their hospitalization. The authors concluded that the rate of healing of the ulcer and the relief of pain was not influenced by treatment with a standard antacid preparation.

Hollander and Harlan,<sup>4</sup> in a controlled, double-blind study on 78 patients with active duodenal or gastric ulceration, showed that antacids were significantly more effective than placebos in the promotion of healing and relief of discomfort of gastric ulcerations. However, in duodenal ulceration, a statistically insignificant trend was found in favor of antacid therapy with respect to promotion of healing and relief of discomfort.

In conclusion, although recommended by noted authorities, there is conflicting clinical data concerning the role of antacids in relief of pain and healing of peptic ulcer.

## References

<sup>1</sup>Peterson WL, *et al*: Healing of duodenal ulcer with an antacid regimen. *N Engl J Med* 297:341-345, 1977.

<sup>2</sup>Sturdevant RAL, *et al*: Antacid and placebo produced similar pain relief in duodenal ulcer patients. *Gastroenterol* 72:1, 1977.

<sup>3</sup>Butler ML and Gersh H: Antacids vs placebo in hospitalized gastric ulcer patients: A controlled therapeutic study. *Digestive Dis* 20:803-807, 1975.

<sup>4</sup>Hollander D and Harlan J: Antacids vs placebo in peptic ulcer therapy: A controlled double-blind investigation. *JAMA* 226:1181-1183, 1973.

## 3. Use of combined dexamethasone insulin injections to treat insulin-induced lipatrophy?

One of the local complications of insulin administration is atrophy of subcutaneous fat at the site of injection (insulin lipatrophy). Subcutaneous fat withers leaving unsightly dimples or pits and usually a complete loss of fat between the skin and underlying muscle.<sup>1</sup> The incidence of this reaction has been up to 24 percent of all diabetic patients utilizing insulin and may be as high as 35 to 50 percent in children. Females are more affected than males. Although insulin lipatrophy is a benign condition, the cosmetic disfigurement is often extremely disturbing to the patient. The recommended treatment is directed toward avoidance of insulin injections into these atrophic areas with the expectation that subcutaneous fat will return. However, this treatment is frequently unsatisfactory.

Although the pathogenesis of insulin lipatrophy has not been established, numerous theories have been advocated including the presence of an unidentified lipolytic substance in commercial insulin,<sup>2</sup> and an immune reaction resulting in lipolysis.<sup>3</sup> Recently support for one or both of these theories has been suggested, as the highly purified ("mono component" and "single peak") insulins (commercially available from Eli Lilly and E. R. Squibb) appear to have lower antigenicity, have reduced the incidence of lipatrophy, and also have been used in its treatment.<sup>2,4,5</sup> Pure insulin itself has a lipogenic effect.

Recently there have been reports concerning the use of trace amounts of dexamethasone (Decadron<sup>®</sup>, Hexadrol<sup>®</sup>), a



substance that may modify the local immune response, in combination with insulin to treat lipoatrophy. When this mixture is injected into lipoatrophic areas, it may result in a reappearance of subcutaneous fat after a period of four to eight months of continuous therapy.

Kumar, *et al.*<sup>1</sup> studied the use of the insulin-dexamethasone mixture, compared to insulin alone, in nine insulin-dependent diabetic patients who had bilateral lipoatrophy of the thighs of one to six years duration.

Utilizing coded vials, the patients were instructed to alternate daily the use of an NPH insulin-dexamethasone mixture (4 mg of dexamethasone per unit of insulin) which was injected into the right thigh; and on the other day, NPH insulin without dexamethasone injected into the left thigh. After four months of therapy there was significant filling of the atrophic areas on the side treated with the insulin-dexamethasone mixture in six of the patients. These six patients remained mostly free of atrophic areas during the follow-up period of over two years.

Whitley, *et al.*<sup>2</sup>, in a case report, described the treatment of widespread lipoatrophy in a 47-year-old woman after subcutaneous injection of isophane (NPH) insulin suspension for five months. Subsequent treatment with a mixture of dexamethasone-insulin zinc suspension (4 micrograms of dexamethasone per unit insulin) into the depressed areas resulted in impressive return of subcutaneous tissue after eight months of continuous therapy.

In conclusion, the mechanism of dexamethasone in the improvement of insulin-induced lipoatrophy is unclear at this time. Further observations with this regimen seems indicated in patients exhibiting lipoatrophy.

#### References

<sup>1</sup>Kumar D, Miller L, and Mehtalia S: Use of dexamethasone in treatment of insulin lipoatrophy. *Diabetes* 26: 296-299, 1977.

<sup>2</sup>Owens JA: U-100 insulins and fat atrophy. *J Hosp Formul Mang* 1:43, 1975.

<sup>3</sup>Whitley T, Lawrence P, Smith C: Amelioration of insulin lipoatrophy by dexamethasone injection. *JAMA* 235:839-840, 1976.

<sup>4</sup>Ferland L, Ehrlich RM: Single-peak insulin in the treatment of insulin-induced fat atrophy. *J Pediatr* 86:71-73, 1975.

<sup>5</sup>Wentworth SM, Galloway EA, *et al*: The use of purified insulins in the treatment of patients with insulin lipoatrophy. *Diabetes* 22 (Suppl I): 290, 1973.

**212th Annual Meeting  
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## Physicians Seeking Location in New Jersey

*The following physicians have written to the Executive Office of MSNJ seeking information on possible opportunities for practice in New Jersey. The information listed below has been supplied by the physician. If you are interested in any further information concerning these physicians, we suggest you make inquiries directly to them.*

**ANESTHESIOLOGY**—Wagdy Farid Aziz, M.D., 7 Hegeman Ave., Apt. 11-G, Brooklyn, New York 11212. Ein Shams Medical College (Egypt) 1964. Board eligible. Solo, partnership, single-specialty group. Available December 1977.

Alan D. Weinstock, M.D., 320 Ocean Parkway, Apt. E-7, Brooklyn 11218. Einstein 1974. Board eligible. Group or partnership. Available July 1978.

Barry S. Wilderman, M.D., 52316-1 Biloxi Circle, Fort Hood, Texas 76544. Temple 1972. Board certified. Solo, specialty group, partnership. Available July 1978.

**FAMILY PRACTICE**—Jon K. Sternburg, M.D., 777 South Mills Street, Madison, Wisconsin, 53715. George Washington University 1974. Board eligible. Group (single specialty). Available September 1978.

Thomas P. Harakal, M.D., 202 Laura Drive, Danville, Pa. 17821. Temple 1975. Board eligible. Group or partnership. Available July 1978.

Lloyd A. Davis, M.D., 3 Dartmouth Ave., Bridge-water 08807. Georgetown 1975. Board eligible. Single specialty group or partnership. Available July 1978.

**GENERAL PRACTICE**—John D. Gawlik, M.D., 464 Chapman Street, Irvington, N.J. 07111. St. Louis University 1969. Group or partnership. Available.

Adaline E. Zalkin, M.D., 250 Beverly Blvd., Upper Darby, Pa. 19082. Guadalajara 1975. Partnership. Available July 1978.

**INTERNAL MEDICINE**—Abdul Rashid Gangoo, M.D., 4 Fairhavenmall, Apt. 14-E, Mineola, New York 11501. University of Kashmir (India) 1969. Subspecialty, infectious diseases. Board eligible (IM). Solo, partnership, group, public health, emergency room. Available July 1978.

Raja G. Bhat, M.D., 1806 Coachmen East, Lindenvold 08021. Christian Medical College, Vellore (India) 1972. Solo, partnership, group. Available July 1978.

Navinchandra M. Amin, M.D., 36 Oakville Drive, Apt. 1-A, Pittsburgh, Pennsylvania 15220. Grant Medical College, Bombay (India) 1961. Subspecialty, cardiovascular diseases. Board certified (IM). Group, partnership, institution Available.

Marvin B. Padnick, M.D., 38 Steamboat Road, Great Neck, New York 11024. Rush Medical College 1973. Subspecialty, cardiovascular diseases. Partnership or group. Available June 1978.

Chun Wen Yang, M.D., 23 Ashwood Drive, Livingston 07039. Kaohsiung (Taiwan) 1969. Subspecialty, hematology/oncology. Board certified (IM). Group. Available July 1978.

Uday V. Gupte, M.D., 1012 Clintonville Street, White-stone, New York 11357. T.N. Medical College, Bom-bay (India). Subspecialty, gastroenterology. Board certified (IM). Partnership or group. Available Janu-ary 1978.

Gerald Einaugler, M.D., 2270 Ocean Avenue, Brook-lyn, New York 11229. University of Bologna (Italy) 1975. Board eligible. Solo, partnership, group. Avail-able July 1978.

M. Ganesharajah, M.D., 50 South Munn Ave., Apt. 420, East Orange 07018, Ceylon 1970. Subspecialty, nephrology. Board eligible. Group, partnership, solo. Available.

Robert E. Greenspan, M.D., 1240 Mulford Road, Columbus, Ohio 43212. University of Maryland 1971. Group, partnership, research. Available July 1978.

Barry Elliot Field, M.D., 4461 Pacific Coast Highway, Apt. C-205, Torrance, California 90505. Einstein. Subspecialty, gastroenterology. Board certified (IM). Group or partnership. Available September 1978.

Hong Joon Kim, M.D., 2014 S. 102nd Street, Apt. 109-C, West Allis, Wisconsin 53227. Seoul National University (Korea) 1970. Board eligible. Partnership or group. Available July 1978.

Myron A. Shoham, M.D., MOQ 3011, Camp Lejeune, North Carolina 28542. Boston University 1971. Sub-specialty, gastroenterology. Board certified (IM). Partnership or group. Available August 1978.

Stephen E. Weinberg, M.D., 663 Cumberland Avenue, Syracuse, New York 13210. Hahnemann 1971. Sub-specialty, cardiology. Board certified (IM). Group, partnership, hospital-based. Available July 1978.

Donald C. Brennan, M.D., 3351 South Port Drive, Sacramento, California 95826. SUNY (Downstate). Subspecialty, hematology/oncology. Board certified (IM). Group or partnership. Available July 1978.

Charles W. Werner, M.D., 151-68 11th Avenue, Whitestone, New York 11357. Bologna (Italy) 1970. Subspecialty, gastroenterology. Board eligible (IM). Group, partnership, solo. Available July 1978.

Ramesh K. Gandhi, M.D., 2210 Mattis Drive, Dayton, Ohio 45439. Amritsar (India). Subspecialty, gastro-enterology. Board certified (IM). Group, partnership, solo. Available July 1978.

John J. Cassel, M.D., 101 Valley Drive, Bolingbrook, Illinois 60439. Jefferson 1973. Subspecialties, cardiol-ogy, pulmonary medicine. Board certified (IM). Any type practice. Available July 1978.

Anilkumar Raotibhai Patel, M.D., Deborah Heart and Lung Center, Browns Mills, New Jersey 08015. Makerere (Uganda) 1970. Subspecialty, cardiology.

Board certified (IM). Group, partnership, institu-tional. Available July 1978.

Barry Sanders, M.D., 9113 Cloisters East, Richmond, Virginia 23229. SUNY (Buffalo) 1973. Subspecialty, gastroenterology. Board certified (IM). Group, part-nership. Available July 1978.

Joseph I. Matthews, M.D., 4708 Iris Street, Rockville, Maryland 20853. Creighton 1969. Subspecialty, pulmonary medicine. Board certified (IM). Group. September 1978.

Bgoki N. Kuppuswamy, M.D., 7507 Riverdale Road, Apt. 2057, New Carrollton, Maryland 20784. Madras (India) 1972. Subspecialty, nephrology. Board eligible (IM). Group, partnership, institutional. Available July 1978.

Thomas Y. Ko, M.D., 131 Sharbot Drive, Pittsburgh, Pennsylvania 15237. Taipei (Taiwan) 1972. Sub-specialty, cardiology. Board eligible (IM). Group, partnership, solo (hospital-based). Available July 1978.

Richard A. Cole, M.D., 98 Sewall Ave., Apt. #1, Brookline, Mass. 02146. Johns Hopkins 1974. Sub-specialty, diabetes and endocrinology. Board certified. Solo, partnership, or group. Available July 1978.

John F. Jacobs, Jr., M.D., 429 Mannor St., Ann Arbor, Michigan 48105. Virginia 1973. Subspecialty, nephrol-ogy. Board certified. Group or hospital. Available July 1978.

Charles L. Starke, M.D., 4540 MacArthur Blvd., Washington, D.C. 20007. Einstein 1975. Board eligible. Partnership, single specialty group, multi-specialty group. Available July 1978.

Duck Sung Chun, M.D., 910 Bellstone St., St. Louis, Mo. 63119. Seoul 1969. Subspecialty, cardiovascular diseases. Board certified. Institution, partnership, research. Available July 1978.

Jonathan Alexander, M.D., 1569 Boulevard, New Haven, Conn. 06511. Einstein 1973. Subspecialty cardiovascular diseases. Board certified. Institution, single specialty group, partnership. Available July 1978.

Romesh K. Japra, M.D., 440 Richard Park East, suite 407, Richmond Heights, Ohio 44143. India Institute of Medicine (New Delhi) 1971. Subspecialty, cardiovascular diseases. Board certified. Multispecialty group, partnership, solo, industrial. Available July 1978.

Thomas Y. Ko, M.D., 131 Sharbot Dr., Pittsburgh, Pa. 15237. Taipei (Taiwan) 1972. Subspecialty, cardio-vascular diseases. Board certified. Partnership, solo, multispecialty group. Available July 1978.

Khalid R. Chaudry, M.D., 250 Beverly Blvd., Upper Darby, Pa. 19082. King Edward (Pakistan) 1971. Subspecialty, cardiovascular diseases. Board certified. Multispecialty group, single specialty group, part-nership. Available July 1978.

Ricky Y. Ho, M.D., 230 Yonkers Ave., Yonkers, N.Y. 10701. Hong Kong 1970. Subspecialty, gastroenterology. Board certified. Single specialty group, multispecialty group, solo. Available July 1978.

Larry I. Good, M.D., 1450 Bittersweet Dr., Blackwood 08012. South Carolina 1973. Subspecialty, gastroenterology. Board certified. Partnership, single specialty group, multispecialty group. Available July 1978.

Rajkumar K. Warriar, M.D., 68-A Manhattan Court, Brooklyn, New York 11235. Calicut, Kerala (India) 1969. Subspecialty, gastroenterology. Board eligible. Institution, research, solo. Available June 1978.

Mary S. Vesoniaraki, M.D., 81 Somerset Ave., Garden City, N.Y. 11530. Athens 1967. Subspecialty, hematology. Board eligible. Institution, multispecialty group, single specialty group. Available July 1978.

Charles A. Henderson, M.D., 6341 Busch Blvd. Columbus, Ohio 43229. Pittsburgh 1973. Subspecialty, hematology. Board certified. Partnership, single specialty group, multispecialty group. Available July 1978.

Adrian A. Bianco, M.D., 6330 Lincoln Ave., Morton Grove, Ill. 60053. Del Salvador (Buenos Aires) 1971. Subspecialties, oncology, hematology. Board certified. Multispecialty group, institution, partnership. Available July 1978.

Carol M. Sholtis, M.D., 2532-F Heather Hills Rd., Toledo, Ohio 43614. Medical College of Ohio 1973. Subspecialty, oncology. Board certified. Single specialty group, multispecialty group, partnership. Available July 1978.

Robert S. Rudenstein, M.D., 275 Bryn Mawr Ave., Bryn Mawr, Pa. 19010. Pittsburgh 1973. Subspecialty, endocrinology. Board certified. Single specialty group, partnership, multispecialty group. Available July 1978.

Raymond J. Casciari, M.D., 2821 North Lowell Lane, Santa Ana, Ca. 92706. Temple 1973. Subspecialty, pulmonary diseases. Board certified. Single specialty group, partnership, solo. Available July 1978.

Stephen M. Kreitzer, M.D., 33 Pond Ave., Brookline, Mass. 02146. Einstein 1971. Subspecialty, pulmonary diseases. Single specialty group, multispecialty group, institution. Available July 1978.

Douglas G. Mufuka, M.D., 608 N. Cuyler Ave., Oak Park, Ill. 60302. SUNY 1973. Subspecialty, nephrology. Board eligible. Single specialty group, institution, multispecialty group. Available July 1978.

David T. Klein, M.D., 4750 Bedford Ave., Brooklyn 11235 (212-743-1839). Brussels 1975. Board eligible. Group or solo. Available July 1978.

Jo U. Choi, M.D., 165 Lyons Ave., Apt. C-6, Newark 07112. Seoul (Korea) 1968. Subspecialty, oncology. Board eligible. Solo, group, partnership, hospital. Available July 1978.

Frederick Lewis, M.D., 445 E. 68th Street, New York 10021. Albany 1971. Subspecialty, endocrinology. Board certified. Group, partnership, or solo. Available July 1978.

Edwin Kolodny, M.D., 60 E. Linden Ave., Englewood 07631. NYU 1973. Subspecialty, pulmonary diseases. Board certified. Group or partnership. Available July 1978.

NEPHROLOGY—Ralph J. Carciana, M.D., 2556 Alderney Lane, Winston-Salem, North Carolina 27103. Tufts 1974. Board eligible. Group. Available July 1978.

NEUROLOGY—Peter J. Barbour, M.D., 1711-A Marshall Court, Los Altos, California 94022. Temple 1974. Group or partnership. Available July 1978.

Wook Chung, M.D., 950 49th Street, Apt. 6-J, Brooklyn, New York 11219. Catholic Medical College (Korea) 1967. Group, partnership, or solo. Available July 1978.

N. D. Karmali, M.D., c/o Daniel Boone Clinic, Harlan, Kentucky 40831. T.N. Medical College, Bombay (India) 1971. Board eligible. Partnership or group. Available January 1978.

Harold P. Wittcoff, M.D., 8842 Meadowbrook Drive, Pensacola, Florida 32501. Georgetown 1969. Board eligible. Group or partnership. Available.

Theodore G. Probst, M.D., 10 Waterside Plaza, New York City 10010. Jefferson 1971. Board eligible. Partnership, single specialty group, multispecialty group. Available July 1978.

OBSTETRICS AND GYNECOLOGY—Wook Chung, M.D., 950 49th St., Apt. 6-J, Brooklyn 11219. Catholic Medical College (Seoul) 1967. Board eligible. Partnership, single specialty group, solo. Available July 1978.

Daniel W. Shapiro, M.D., 6812 Criner Rd., Huntsville, Ala. 35802. NYU 1971. Board eligible. Single specialty group, partnership, multispecialty group. Available August 1978.

Akbar Omar, M.D., 85 Riverdale Ave., Yonkers, N.Y. 10701. Dow Medical (Pakistan) 1972. Board eligible. Multispecialty group, partnership, solo. Available July 1978.

Leonard Weather, Jr., M.D., 601 N. Broadway, Baltimore 21205. Rush 1974. Board eligible. Solo, research, partnership, single specialty group, institution, multispecialty group. Available July 1978.

Kenneth A. Desandies, M.D., 668 Lenox Rd., Brooklyn, NY 11203. Meharry 1973. Board eligible. Multispecialty group, single specialty group, partnership. Available August 1978.

Fa-Tsair Shieh, M.D., 808 Massachusetts Ave., Luray, Virginia 22835. China Medical (Taiwan) 1970. Board eligible. Solo, associate, group. Available.



**OPHTHALMOLOGY**—Allan Stuart Markowitz, M.D., 3535 Rochambeau Avenue, Apt. 2-L, Bronx, New York 10467. Einstein 1974. Board eligible. Group, partnership, solo, or institutional. Available July 1978.

Dion R. Ehrlich, M.D., 5148-A Long Branch Lane, Columbus, Ohio 43213. George Washington 1973. Board eligible. Single specialty group, partnership, solo. Available July 1978.

Miguel Pro, M.D., 801 Cooper Landing Rd., Cherry Hill 08002. Cayetano Heredia (Lima, Peru) 1972. Board eligible. Institution. Available January 1978.

Kenneth J. Wolf, M.D., 3555 Bainbridge Ave., Bronx, N.Y. 10467. Einstein 1974. Board eligible. Solo, group. Available July 1978.

**ORTHOPEDIC SURGERY**—Alfred C. Lotman, M.D., 1640 Johnson Avenue, Apt. 162-B, Petersburg, Virginia 23801. Tulane 1971. Board certified. Group. Available.

**OTOLARYNGOLOGY**—Jeffrey M. Rosenbaum, M.D., 1575 Center Avenue, Apt. 3-D, Fort Lee 07024. Albany 1973. Partnership or group. Available July 1978.

**PATHOLOGY**—Kanchan A. Shimpi, M.D., 1 Hospital Dr., Cheverly, Md. 20785. B.J. Medical (India) 1969. Board eligible. Institution, multispecialty group, single specialty group. Available 1978.

**PEDIATRICS**—Susan R. De Castro, M.D., East 16th Street, Alma, Georgia 31510. Far Eastern (Philippines) 1965. Board eligible. Group, partnership, solo, or public health. Available April 1978.

Winston A. Rajasingham, M.D., 2620 Ocean Parkway, Apt. 4-F, Brooklyn, New York 11235. Sri Lanka (Ceylon) 1968. Group, partnership, associate. Available.

Joseph M. Chettupuzha, M.D., 21 Heywood Street, Apt. 2-D, Worcester, Massachusetts 01604. KMC (India) 1973. Group or partnership. Available July 1978.

Leo P. Pajarillo, M.D., 2503-A Atlas Drive, Rome, New York 13440. Cebu (Philippines) 1968. Board eligible. Group, partnership, solo. Available July 1978.

Reynaldo G. Maniago, M.D., 784-A Bayshore Dr., MacDill AFB, Tampa, Fla. 33621. University of the East (Philippines) 1971. Also general practice. Board eligible. Solo, multispecialty group, single specialty group, partnership, emergency room, institution. Available July 1978.

An-Shuang Tsai, M.D., 1255 Pennsylvania Ave., Apt. 8-D, Brooklyn 11239. Kaoshiung Medical 1971. Subspecialty, hematology. Board eligible. Group, partnership, hospital. Available July 1978.

Vojislava C. Russo, M.D., 532 E. Wimbledon Dr., Charleston S.C. 29412. Downstate 1973. Board eligible. Group, partnership, hospital. Available July 1978.

Prasao C. Kakarala, M.D., 7545 E. Treasure Dr., Apt. 4-J, Miami Beach, Fla. 33141. Rangaraya Medical (India) 1971. Board eligible. Group, partnership, solo, clinic, multispecialty group.

Asuncion M. Macasinag, M.D., 96 Fleet Pl., Mineola, N.Y. 11501. Santo Tomas (Philippines) 1971. Board eligible. Any type of practice. Available July 1978.

**PULMONARY DISEASES**—A. Shanmuganathan, M.D., 394 Tremont Ave., B-1, East Orange 07018. Ceylon 1972. Group, partnership, solo. Available July 1978.

**RADIOLOGY**—Devchand V. Patel, M.D., 1100 Parsippany Blvd., Parsippany 07054. B.J. Medical (India) 1962. Diagnostic radiology. Board eligible. Single specialty group. Available July 1978.

Arturo E. Macasinag, M.D., 96 Fleet Pl., Mineola, N.Y. 11501. Santo Tomas (Philippines) 1971. Board eligible. Any type of practice. Available July 1978.

**SURGERY**—Martin Gewecke, M.D., 143-11 Kirkbride Road, Voorhees Township 08043. Munich 1967. Board eligible. Group, partnership, hospital. Available January 1978.

Manuel S. DiJamco, M.D., 1432 Arch Street, Apt. B-201, Norristown, Pennsylvania 19401. Manila Central University (Philippines) 1952. Group, partnership, or solo. Available July 1978.

Yahya O. Labban, M.D., 9303 Hammerly, Apt. 703, Houston, Texas 77080. French Faculty, Beirut (Lebanon) 1955. Subspecialty, general practice. Board eligible (Surgery) Group, solo. Available.

Eugene P. Russo, M.D., 532 E. Wimbledon Dr., Charleston, S.C. 29412. Georgetown 1971. Board eligible. Group, partnership, hospital. Available July 1978.

Howard Floch, M.D., 255 E. 23rd St., New York City 10010. Hahnemann 1972. Board eligible. Subspecialty, peripheral vascular with non-cardiac thoracic. Partnership or group involving residency training program. Available July 1978.

Andrew Grimes, M.D., 301 E. 48th St., Apt. 9-B, New York City 10017. Harvard 1972. Partnership, associate, group. Available July 1978.

Arnold W. Berlin, M.D., 305 Zion St., Hartford, Conn. 06106. NYU 1972. Board eligible. Group, partnership, solo. Available July 1978.

Steven R. Hofstetter, M.D., 932 Van Court Ave., Elberon 07740. Upstate Medical 1971. Board eligible. Partnership, single specialty group, multispecialty group. Available June 1978.

Ajmal Sobhan, M.D., 7703 21st Ave., Jackson Heights, N.Y. 11370. Dacca (Pakistan) 1972. Subspecialty, cardiovascular surgery. Board eligible. Partnership, single specialty group, multispecialty group. Available July 1978.

Kamalakar R. Ayyagari, M.D., 555 Mt. Prospect Ave., Apt. 10-G, Newark 07104. Gandhi (India) 1967.

Board eligible. Solo, partnership, multispecialty group. Available July 1978.

Carlos J. Jimenez, M.D., 543 Riley St., Buffalo, N.Y. 14208. Barcelona 1971. Board eligible. Multispecialty group, single specialty group, partnership. Available July 1978.

Michael F. Nigro, M.D., 445 E. 68th St., Apt. 5-D, New York City 10021. Cornell 1970. Subspecialty, head and neck surgery. Board eligible. Single specialty group, partnership, multispecialty group. Available July 1978.

Ronald B. Greene, M.D., 4625 Cutlass Dr., Englewood, Ohio 45322. Temple 1972. Subspecialty, orthopedic surgery. Board eligible. Single specialty group, partnership, multispecialty group. Available July 1978.

Jeffrey H. Phillips, M.D., 3450-23 Wayne Ave., Bronx, N.Y. 10467. Einstein 1974. Subspecialty, orthopedic surgery. Board eligible. Single specialty group, partnership, solo. Available July 1978.

Roger A. Evans, M.D., 316 Wilderness Rd., Hampton, Va. 23669. SUNY 1970. Subspecialty, urological surgery. Board eligible. Single specialty group, multispecialty group, partnership. Available July 1978.

Richard Dias, M.D., 1090 Amsterdam Ave., Apt. 13-G, New York City 10025. Bangalore (India) 1969. Subspecialty, urological surgery. Board eligible. Available June 1978.

Alan H. Lieberman, M.D., 706 Schiller Ave., Narberth, Pa. 19072. Pennsylvania 1971. Subspecialty, urological surgery. Board eligible. Single specialty group, partnership, multispecialty group, solo. Available July 1978.

Lawrence J. Yodlowski, M.D., 2532-F Heather Hills Rd., Toledo, Ohio 43614. Medical College of Ohio 1973. Subspecialties, urological surgery and emer-

gency medicine. Single specialty group, multispecialty group, partnership.

Noel T. Hui, M.D., 708 Choctaw Dr., Eglin AFB, Florida 32542. National Defense Medical Center (Taiwan) 1970. Subspecialty, urological surgery. Board eligible. Single specialty group, multispecialty group, solo. Available July 1978.

Richard O. Healy, M.D., 2793 Agricola St., Halifax, B3K, 4E3, Nova Scotia, Canada. University College (Dublin, Ireland) 1970. Subspecialty, urological surgery. Board eligible. Single specialty group, partnership, research. Available January 1978.

T. R. A. Adaniel, M.D., 310 West 56th St., New York City 10019. Santo Tomas (Philippines) 1964. Board certified. Solo or Group. Available.

Manuel S. Dijamco, M.D., 906 Main St., Riverton 08077. Manila Central (Philippines) 1965. Board eligible. Solo or partnership. Available July 1978.

UROLOGY — Louis D'Amico, M.D., 1061 Renfield Road, Cleveland Heights, Ohio 44121. Hahnemann 1973. Group, partnership, solo. Available July 1978.

V. R. Goli, M.D., 195 Deveron Crescent, London, Ontario, Canada N52 4J4. Guntur (India) 1962. Board eligible. Group, partnership, or solo. Available July 1978.

E. Unnikrishnan, M.D., 1895 Belmore Road, East Cleveland, Ohio 44112. Calicut (India). Group, partnership, solo. Available.

Michael Barr, M.D., 3450-10 Wayne Avenue, Bronx, New York. SUNY (Downstate) 1972. Solo or partnership. Available July 1978.

Richard Dias, M.D., 1090 Amsterdam Ave., Apt. 13-G, New York City 10025. Bangalore (India) 1969. Board eligible. Solo, single specialty or multispecialty group. Available June 1978.

# 212th Annual Meeting May 6-9

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**See housing application — p. 1081, this issue**

# ANNOUNCEMENTS

## Management of Hyperlipidemias

The College of Medicine and Dentistry of New Jersey, Office of Continuing Education, will present an "Update in the Management of Hyperlipidemias" on December 14 at the Rutgers Medical School in Piscataway. Tuition for the all-day program (9 a.m. to 4:30 p.m.) is \$35, which includes luncheon. Six credit hours will be granted in Category I of the AMA Physician's Recognition Award, and by the American Academy of Family Physicians and the American Dietetic Association. Participants in the program will be general internists, cardiologists, general practitioners, and dietitians. For application and additional information, please communicate with the Office of Continuing Education, CMDNJ, P.O. Box 101—University Heights, Piscataway, New Jersey 08854—(201) 564-4707.

## CME Seminar in Virgin Islands

From January 26 to 28, 1978, the third Mid-Winter Virgin Islands Clinical Conference for primary physicians will be held in St. Thomas. The program is arranged by the Virgin Islands Medical Society, in association with the faculty of the Johns Hopkins University School of Medicine. Included will be lectures and seminars for physicians in general practice, internists, general surgeons, pediatricians, and obstetricians/gynecologists. The program has been approved for 14 credit hours in the AMA Physician's Recognition Award. For additional information, please write to Peter A. Curreri, M.D., III Annual Clinical Conference, Box 39, Red Hook, St. Thomas, Virgin Islands 00801.

## Symposium on Clinical Syndromes

From January 30 through February 1, under the auspices of the Department of Continuing Medical Education of Temple University Medical School, a symposium on "Important Clinical Syndromes: Diagnosis and Management" will be presented by the Pico Peak Medical Association and held at the Pico Ski

Area, Rutland, Vermont. For program and lodging information please communicate with John W. Holland, M.D., 4 S. Haverford Ave., Margate, New Jersey 08402—(609) 822-5932.

## The OB/GYN Patient

"Menarche to Menopause: The Primary Care of the OB/GYN Patient" will be presented by the Family Medicine Program and the Program of Continuing Education of the University of Maryland School of Medicine on February 18 and 19, 1978 at the Cross Keys Inn, Baltimore. Emphasis will be on the primary care of the female patient, involving an understanding of the physiologic changes that occur over time, and an assessment and treatment of common female disorders. The course is designed around actual case histories. For additional information, please communicate with the Program of Continuing Education, University of Maryland School of Medicine, 655 West Baltimore Street, Baltimore, Maryland—(301) 529-7346.

## New Orleans Graduate Medical Assembly

From March 31 through April 4 the New Orleans Graduate Medical Assembly will be held at the Fairmount in New Orleans. Theme for the scientific program is "The High Risk Patient" and included in the schedule are a trauma symposium and clinicopathologic conferences. Scientific and technical exhibits will be presented. Physicians attending the scientific sessions of this Assembly will be considered as having met the criteria for the AMA's Category I Physician's Recognition Award. Application for credit hours has been made also to the American Academy of Family Physicians and to the American College of Emergency Physicians. For additional information, please communicate with Ms. Lois Neary, Executive Director, The New Orleans Graduate Medical Assembly, 1430 Tulane Avenue, New Orleans, Louisiana 70112.



## Harvard Programs in Health Management

Harvard University announces the following two executive education programs in health management for 1978:

*Health Systems Management*—June 18 to July 28—Designed for senior managers in health care delivery—Application due March 15

*Management Development Program in Health*—April 2 to 20—Designed for mid-level managers in health care delivery—Application due February 7

The curricula of the two programs differ insofar as they are designed to address the needs of executives at different stages in their career development. Included are courses in financial management, marketing management, control, health economics, legal issues, organizational issues, health services, operations management, labor relations, and institutional policy and strategy. The faculty have been drawn from the Harvard graduate schools of Public Health, Business, and Medicine. Applicants must be

sponsored by their employer organizations, which are responsible for the program fees. Inquiries should be addressed to the Administrative Director, PHSM/MDPH, Executive Programs in Health Policy and Management, Harvard School of Public Health, 677 Huntington Avenue, Boston, Massachusetts 02115.

### ✓ Correction

*The Journal* calls attention to an error in the placement of illustrations 1A and 2A of the article, "Transient Ischemia of the Small Bowel Secondary to Lupus Vasculitis"—Alan J. Simpson, M.D. (*J Med Soc NJ* 74:869, October 1977) They should be transposed, one with the other, to correspond properly with the legends for Figure 1A and Figure 2A.

## MEETINGS OF MEDICAL INTEREST

This listing is compiled through the cooperation of the Committee on Medical Education of The Medical Society of New Jersey, the Academy of Medicine of New Jersey, the New Jersey Chapter of the American Academy of Family Physicians, and the Office of Continuing Medical Education of the College of Medicine and Dentistry of New Jersey. For information on accreditation, please contact the sponsoring organization(s), indicated by italics—last line of each item.

Dec.

- |  |  |
|--|--|
| 12 Neuroscience Conference   | 13 Medical/Legal Aspects of Medicine and Surgery   |
| 19 11:30 a.m.-12:30 p.m. — Bergen Pines County Hospital<br>Paramus<br>( <i>Bergen Pines County Hospital and AMNJ</i> ) | 9 p.m. — Bayonne Hospital<br>( <i>AMNJ and AAFP</i> )  |
| 13 Nuclear Medicine for the Practitioner   | 14 Clinical E.E.G.   |
| 8-9 a.m. — Garden State Community Hospital<br>Marlton<br>( <i>Garden State Community Hospital and AMNJ</i> )           | 1 p.m. — Christ Hospital, Jersey City<br>( <i>Christ Hospital</i> )                                      |
| 13 Alcoholic Heart Disease   | 14 Psychopharmacology  |
| 20 Tuberculosis  | 1:30-3:30 p.m. — Trenton Psychiatric Hospital<br>( <i>Trenton Psychiatric Hospital and AMNJ</i> )        |
| 11 a.m.-12 noon — Greystone Park Psychiatric<br>Hospital<br>( <i>Greystone Park Psychiatric Hospital and AMNJ</i> )    | 14 Treatment and Prevention of Violence Among Youth  |
| 13 Obesity and Hypoglycemia  | 8:30-10:30 p.m. — Guido's Restaurant, Hackensack<br>( <i>North Jersey Psychiatric Society and AMNJ</i> ) |
| 8 p.m. — Paul Kimball Hospital<br>( <i>AMNJ and AAFP</i> )   | 14 Continuing Education Lectures in Psychiatry   |
|  | 1-3 p.m. — Ancora Psychiatric Hospital, Hammonton<br>( <i>Ancora Psychiatric Hospital and AMNJ</i> )     |

- 14 Polycythemia Vera**  
**21 Aspirin for the Limping Brain**  
**28 Clinical Pathology Conference**  
 9:30-11:30 a.m. — Bergen Pines County Hospital  
 Paramus  
*(AMNJ and AAFP)*
- 14 Multidisciplinary Approach to Cancer**  
**21 2-4 p.m. — Newark Beth Israel Medical Center**  
*(Newark Beth Israel Medical Center and AMNJ)*
- 14 EKG for the Practitioner**  
**21 9-11 a.m. — West Jersey Hospital, Voorhees**  
**28** *(West Jersey Hospital and AAFP)*
- 14 Sex Therapy**  
**28 Traumatic Surgery and Shock**  
 9-11 a.m. — Riverview Hospital, Red Bank  
*(Riverview Hospital and AMNJ)*
- 14 Management of Hyperlipidemias**  
 9 a.m.-4:30 p.m. — Rutgers Medical School  
 Piscataway  
*(CMDNJ, AMNJ and AAFP)*
- 15 Pediatric Allergy Course**  
**22 11 a.m.-12 noon — Children's Hospital of Newark**  
*(Children's Hospital of Newark and AMNJ)*
- 15 Syphilis and the Clinician**  
 3:30-4:30 p.m. — Burlington Co. Memorial Hospital  
 Mount Holly  
*(Burlington Co. Memorial Hospital)*
- 15 Current Concepts in Modern Biology**  
 4-6 p.m. — Institute for Medical Research, Camden  
*(Institute for Medical Research and AMNJ)*
- 15 Case Presentation**  
**22 Treatment of the Schizophrenic Family**  
**29 Treatment of the Schizophrenic Family**  
 11 a.m.-12 Noon — Greystone Park Psychiatric  
 Hospital  
*(Greystone Park Psychiatric Hospital and AMNJ)*
- 15 Endoscopy**  
 6:15 p.m. — Bridgeton Hospital  
*(Bridgeton Hospital)*
- 15 Spinal Cord Injury Update**  
 1-3 p.m. — VA Hospital, East Orange  
*(VA Hospital and AMNJ)*
- 15 Discovering and Treating the Alcoholic**  
 11:45 a.m. — Kennedy Medical Center, Edison  
*(Ayerst Laboratories and Kennedy Medical Center)*
- 15 Pre and Postoperative Care in TCV**  
**19 Congenital Heart Defects**  
**22 TBC and Fungal Diseases of Lungs**  
**29 Hematology and the Surgical Patient**  
 5-6 p.m. — St. Francis Medical Center, Trenton  
*(St. Francis Medical Center)*
- 16 Management of Hepatitis**  
 5 p.m. — Salem County Medical Society  
*(AMNJ and AAFP)*

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4.

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**19 Surgical Management of Ulcerative Colitis**  
12 noon—Hospital Center at Orange  
(AMNJ and AAFP)

**20 Disseminated Intravascular Coagulation**  
12 noon—St. Mary's Hospital, Orange  
(AMNJ and AAFP)

**21 Hypertension—Renal Vascular**  
11 a.m.-12 noon—Greystone Park Psychiatric Hospital  
(Greystone Park Psychiatric Hospital and AMNJ)

**21 Common Medical Problems for the Family Physician**  
8 a.m.—S. Ocean County Hospital, Manahawkin  
(Burlington County Memorial Hospital and AAFP)

**21 Suicidology**  
3:15 p.m.—Fair Oaks Hospital, Summit  
(AMNJ and AAFP)

**21 Special Problems in Neurology**  
7-10 p.m.—VA Hospital, East Orange  
(VA Hospital and AMNJ)

**21 Evaluating and Treating Essential Hypertension**  
1-2 p.m.—VA Hospital, Lyons  
(VA Hospital and AMNJ)

**27 Clinical Pathological Conference**  
1-2 p.m.—Trenton Psychiatric Hospital  
(Trenton Psychiatric Hospital and AMNJ)

**28 Radiology**  
8-9 a.m.—So. Ocean County Hospital, Manahawkin  
(Burlington County Memorial Hospital and AAFP)

**30 Medical Care in Emergency Department**  
12:30 p.m.—Hamilton Hospital, Trenton  
(AMNJ and AAFP)

Jan.

**2 Medical Care in Emergency Department**  
8 p.m.—Community Memorial Hospital, Toms River  
(AMNJ and AAFP)

**3 Peripheral Vascular Disease**  
11 a.m.—Greystone Park Psychiatric Hospital  
(AMNJ and AAFP)

**4 Advances in Medicine**  
**11** 9:30-11 a.m.—Bergen Pines County Hospital, Paramus  
**18** (Bergen Pines County Hospital and AMNJ)

**25**

**4 Cardiology Conferences**  
**18** 4-6 p.m.—Rutgers Medical School, Piscataway  
(CMDNJ and AMNJ)

**4 New Developments in Scanning**  
3:15 p.m.—Fair Oaks Hospital, Summit  
(AMNJ and AAFP)

**4 Psychiatric Aspects of Endocrinology**  
1 p.m.—Christ Hospital, Jersey City  
(AMNJ and AAFP)



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- 4 **Lectures in Obstetrics/Gynecology**  
6-10 p.m. — 141 S. Harrison St., E. Orange  
(*New Jersey Medical School and AMNJ*)
- 4 **Psychiatry**  
18 1-3 p.m. — Ancora Psychiatric Hospital, Hammonton  
25 (*Ancora Psychiatric Hospital and AMNJ*)
- 5 **Pediatric Allergy Course**  
12 11 a.m.-12 noon — Children's Hospital of Newark  
19 (*Children's Hospital of Newark and AMNJ*)  
26
- 5 **Infectious Disease Course**  
8:30-9:30 a.m. — Somerset Hospital, Somerville  
(*Somerset Hospital and AMNJ*)
- 5 **Current Concepts in Modern Biology**  
12 4-6 p.m. — Institute for Medical Research, Camden  
19 (*Institute for Medical Research and AMNJ*)  
26
- 5 **Thyroid Function Testing**  
11:45 a.m. — Kennedy Medical Center, Edison  
(*Armour Pharmaceutical and Kennedy Medical Center*)
- 6 **Outpatient Management of Tuberculosis**  
8:30 a.m. — United Hospitals of Newark  
(*AMNJ and AAFP*)
- 9 **Neuroscience Conferences**  
16 11:30 a.m.-12:30 p.m. — Bergen Pines County Hospital  
23 Paramus  
30 (*Bergen Pines County Hospital and AMNJ*)
- 10 **Arthritis**  
12 noon — Hospital Center at Orange  
(*AMNJ and AAFP*)
- 10 **Genetics**  
8 p.m. — Paul Kimball Hospital, Lakewood  
(*AMNJ and AAFP*)
- 10 **Amenorrhea**  
12 **Narcolepsy**  
11:45 a.m. — Kennedy Medical Center, Edison  
(*Kennedy Medical Center*)
- 10 **Malignant Melanoma**  
8-10 p.m. — Schering Corporation, Kenilworth  
(*New Jersey Dermatological Society and AMNJ*)
- 10 **Splenectomy for Hematologic Disease**  
5-6 p.m. — Rutgers Medical School, Piscataway  
(*Rutgers Medical School and AMNJ*)
- 11 **Mechanical and Drug Therapy in Cardiogenic Shock**  
18 **Mitral Prolapse: Current Concepts**  
25 **Electrophysiologic Techniques in the Management of Arrhythmias**  
10-11:30 a.m. — St. Michael's Medical Center, Newark  
(*St. Michael's Medical Center and AMNJ*)
- 11 **Cerebral Vascular Disease**  
11:30 a.m. — Rahway Hospital  
(*AMNJ and AAFP*)
- 11 **Fluid and Electrolyte Imbalance**  
1:30 p.m. — John E. Runnells Hospital, Berkeley Heights  
(*AMNJ and AAFP*)
- 11 **The Irritable Bowel Syndrome**  
1-3:30 p.m. — VA Hospital, Lyons  
(*VA Hospital and AMNJ*)
- 11 **Ischemic Heart Disease**  
1-3 p.m. — Christ Hospital, Jersey City  
(*Christ Hospital, AMNJ and AAFP*)
- 14 **CME Program**  
28 8-10 a.m. — Newcomb Hospital, Vineland  
(*University of Pennsylvania School of Medicine and AAFP*)
- 14 **Advanced Cardiac Life Support — A Course for Providers**  
15 Hunterdon Central High School, Flemington  
(*Hunterdon Medical Center and AAFP*)
- 15 **Special Problems in Neurology**  
7-10 p.m. — VA Hospital, East Orange  
(*VA Hospital and AMNJ*)
- 15 **Shock**  
1-3 p.m. — Christ Hospital, Jersey City  
(*Christ Hospital and AMNJ*)
- 17 **Northern Regional Chest Conferences**  
7:30-9:30 p.m. — Mountainside Hospital, Montclair  
(*New Jersey Thoracic Society and AMNJ*)
- 17 **Pulmonary Embolism**  
12 noon — St. Mary's Hospital, Orange  
(*AMNJ and AAFP*)
- 17 **Role of Anesthesiologists in an Ambulatory Surgical Unit**  
8-9 p.m. — Ramada Inn, Clark  
(*NJ State Society of Anesthesiologists and AMNJ*)
- 18 **Special Problems in Neurology**  
7-10 p.m. — VA Hospital, East Orange  
(*VA Hospital and AMNJ*)
- 18 **Advanced Life Support in CPR**  
1 p.m. — Trenton Psychiatric Hospital  
(*AMNJ and AAFP*)
- 18 **Medical Humanism-Hospital Ethics**  
3:15 p.m. — Fair Oaks Hospital, Summit  
(*AMNJ and AAFP*)
- 18 **Rectal Cancer**  
1-3 p.m. — Christ Hospital, Jersey City  
*Christ Hospital & AAFP*
- 18 **Sleep Disorders — Part I**  
1-2 p.m. — VA Hospital, Lyons  
(*VA Hospital and AMNJ*)
- 18 **Psychiatry — Special Patient Syndrome**  
1:15-2:45 p.m. — Marlboro Psychiatric Hospital  
(*Marlboro Psychiatric Hospital and AMNJ*)

- 19 **Urinary Tract Infections**  
11:45 a.m. — Kennedy Medical Center, Edison  
(*Eaton Laboratories and Kennedy Medical Center*)
  - 19 **Cellular Engineering in Medicine**  
5-6:30 p.m. — Somerset Hospital, Somerville  
(*Somerset Hospital and AMNJ*)
  - 19 **Advances in Nephrology**  
6:15 p.m. — Bridgeton Hospital  
(*Bridgeton Hospital*)
  - 24 **Allergy**  
8 p.m. — Warren Hospital, Phillipsburg  
(*AMNJ and AAFP*)
  - 25 **Evaluation of Hemorrhagic and Bleeding Disorders**  
1-2 p.m. — VA Hospital, Lyons  
(*VA Hospital and AMNJ*)
  - 25 **Inflammatory Bowel Disease**  
(Albert Siegel Memorial Seminar)  
1 p.m. — St. Barnabas Medical Center, Livingston  
(*St. Barnabas Medical Center and AMNJ*)
  - 26 **Office Management of Common Gastrointestinal Problems**  
11:45 a.m. — Kennedy Medical Center, Edison  
(*Searle Laboratories and Kennedy Medical Center*)
  - 27 **Cardiac Arrhythmias**  
12:30 p.m. — Hamilton Hospital, Trenton  
(*AMNJ and AAFP*)
- Feb.
- 1 **Cardiology Conferences**
  - 15 4-6 p.m. — Rutgers Medical School, Piscataway  
(*CMDNJ and AMNJ*)
  - 1 **Advances in Medicine**
  - 8 9:30-11 a.m. — Bergen Pines Hospital, Paramus  
(*Bergen Pines County Hospital and AMNJ*)
  - 15
  - 22
  - 1 **Cerebral Vascular Disease**  
1 p.m. — Christ Hospital, Jersey City  
(*AMNJ and AAFP*)
  - 1 **Total Joint Replacement and Bone Tumors**
  - 8 **Lithium and Affective Disorders**
  - 15 **Dermatologic Manifestations of Systemic Diseases**
  - 22 **Infection in the Compromised Host**  
9-11 a.m. — Riverview Hospital, Red Bank  
(*Riverview Hospital, AMNJ and AAFP*)
  - 1 **Psychiatry**
  - 7 1-3 p.m. — Ancora Psychiatric Hospital, Hammonton  
(*Ancora Psychiatric Hospital and AMNJ*)
  - 15
  - 1 **Coronary Artery Disease**
  - 8 **Assynergy in Coronary Heart Disease — 1978**
  - 15 **New Aspects of Echocardiography**
  - 22 **High Density Lipoproteins**  
10-11:30 a.m. — St. Michael's Medical Center, Newark  
(*St. Michael's Medical Center and AMNJ*)
  - 1 **Lectures in Obstetrics/Gynecology**  
6-10 p.m. — 141 S. Harrison St., E. Orange  
(*New Jersey Medical School and AMNJ*)
  - 2 **Current Concepts in Modern Biology**
  - 9 4-6 p.m. — Institute for Medical Research, Camden  
(*Institute for Medical Research and AMNJ*)
  - 16
  - 23
  - 2 **Care of the Aged Post-Hip Fracture Patient**  
2-4 p.m. — Daughters of Miriam Center, Clifton  
(*Daughters of Miriam Center for the Aged and AMNJ*)
  - 2 **Pediatric Allergy Course**
  - 9 11 a.m.-12 noon — Children's Hospital of Newark  
(*Children's Hospital of Newark and AMNJ*)
  - 16
  - 23
  - 2 **Infectious Disease Course**  
8:30-9:30 a.m. — Somerset Hospital, Somerville  
(*Somerset Hospital and AMNJ*)
  - 2 **Diabetes**  
11 a.m. — Greystone Park Psychiatric Hospital  
(*AMNJ and AAFP*)
  - 3 **Proper Uses of Blood Gases**  
8:30 a.m. — United Hospitals of Newark  
(*AMNJ and AAFP*)
  - 3-5 **Basic Clinical Electrocardiography and Arrhythmia Management**  
Playboy Resort, Great Gorge  
(*International Medical Education Corporation and AAFP*)
  - 6 **Neuroscience Conferences**
  - 13 11:30 a.m.-12:30 p.m. — Bergen Pines County Hospital
  - 20 Paramus
  - 27 (*Bergen Pines County Hospital and AMNJ*)
  - 6 **Headache**  
8 p.m. — Community Memorial Hospital, Toms River  
(*AMNJ and AAFP*)
  - 7 **Complications of Vascular Surgery**  
5-6 p.m. — Rutgers Medical School, Piscataway  
(*Rutgers Medical School and AMNJ*)
  - 7 **Neonatal Emergencies**  
9 a.m. — Freehold Area Hospital  
(*AMNJ and AAFP*)
  - 8 **Peripheral Vascular Disease**  
11:30 a.m. — Rahway Hospital  
1:30 p.m. — John E. Runnells Hospital, Berkeley Heights  
(*AMNJ and AAFP*)
  - 8 **Sleep Disorders — Part II**  
1-2 p.m. — VA Hospital, Lyons  
(*VA Hospital and AMNJ*)
  - 8 **Psychiatric Malpractice**  
1:15-2:45 — Marlboro Psychiatric Hospital  
(*Marlboro Psychiatric Hospital and AMNJ*)

- 11 CME Program**  
**25** 8-10 a.m. — Newcomb Hospital, Vineland  
*(University of Pennsylvania School of Medicine and AAFP)*
- 11 Seminar in Anesthesiology**  
 9 a.m.-3 p.m. — New Jersey Medical School, Newark  
*(Educational Council for Anesthesiology of NJ and AMNJ)*
- 14 Hyponitremia: Hypokalemia**  
 8 p.m. — Paul Kimball Hospital, Lakewood  
*(AMNJ and AAFP)*
- 14 Evaluation and Treatment of the Dizzy Patient**  
 6-10 p.m. — Englewood Hospital  
*(Bergen County Society of Otolaryngologists and AMNJ)*
- 14 Emergency Room Dermatology**  
 8-10 p.m. — Schering Corporation, Kenilworth  
*(New Jersey Dermatological Society and AMNJ)*
- 15 Medical Humanism-Hospital Ethics**  
 1 p.m. — Trenton Psychiatric Hospital  
*(AMNJ and AAFP)*
- 16 Appropriate Workup for the Headache Patient**  
 5-6:30 p.m. — Somerset Hospital, Somerville  
*(Somerset Hospital and AMNJ)*
- 16 Problems in Biliary Tract Surgery**  
 6:15 p.m. — Bridgeton Hospital  
*(Bridgeton Hospital)*
- 17 Laboratory Interpretations**  
 5 p.m. — Holiday Inn, Deepwater  
*(AMNJ and AAFP)*
- 17 Endocrinology**  
 12 noon — Freehold Area Hospital  
*(AMNJ and AAFP)*
- 20 Current Surgical Techniques of Breast Cancer**  
 12 noon — Hospital Center at Orange  
*(AMNJ and AAFP)*
- 20- Endocrinology Symposium**  
**24** Nassau, Bahamas  
*(CMDNJ, AMNJ and VA Hospital, East Orange)*
- 21 Northern Regional Chest Conferences**  
 7:30-9:30 p.m. — St. Barnabas Hospital, Livingston  
*(New Jersey Thoracic Society and AMNJ)*
- 21 Cancer of the Colon and Ovary**  
 12 noon — St. Mary's Hospital, Orange  
*(AMNJ and AAFP)*
- 24 Carcinoma of the Breast**  
 12:30 p.m. — Hamilton Hospital, Trenton  
*(AMNJ and AAFP)*
- 28 Drug Addiction**  
 8 p.m. — Warren Hospital, Phillipsburg  
*(AMNJ and AAFP)*

# Mar.

- 1 Advances in Medicine**  
**8** 9:30-11 a.m. — Bergen Pines County Hospital, Paramus  
**15** *(Bergen Pines County Hospital and AMNJ)*  
**22**  
**29**
- 1 Cardiology Conferences**  
**15** 4-6 p.m. — Rutgers Medical School, Piscataway  
*(CMDNJ and AMNJ)*
- 1 Proper Use of Blood Gases**  
 11:30 a.m. — Rahway Hospital  
*(AMNJ and AAFP)*
- 1 Fiberoptic Bronchoscopy**  
 1 p.m. — Christ Hospital, Jersey City  
*(AMNJ and AAFP)*
- 1 Courses for Psychiatrists**  
**8** 8-10 p.m. — Hackensack Hospital  
**15** *(NJ Psychoanalytic Society and AMNJ)*  
**22**  
**29**
- 1 Immunology in Clinical Medicine**  
**8** **Controversies in Breast Cancer**  
**15** **Acupuncture**  
 9-11 a.m. — Riverview Hospital, Red Bank  
*(Riverview Hospital, AMNJ and AAFP)*
- 1 Psychiatry**  
**15** 1-3 p.m. — Ancora Psychiatric Hospital  
**20** *(Ancora Psychiatric Hospital and AMNJ)*  
**29**
- 1 Lectures in Obstetrics/Gynecology**  
 6-10 p.m. — 141 S. Harrison St., E. Orange  
*(New Jersey Medical School and AMNJ)*
- 1 Cardiac Rehabilitation: A Three-Year Experience**  
 10-11:30 a.m. — St. Michael's Medical Center, Newark  
*(St. Michael's Medical Center and AMNJ)*
- 2 Pediatric Allergy Course**  
**9** 11 a.m.-12 noon — Children's Hospital of Newark  
**16** *(Children's Hospital of Newark and AMNJ)*  
**23**
- 2 Current Concepts in Modern Biology**  
**9** 4-6 p.m. — Institute for Medical Research, Camden  
**16** *(Institute for Medical Research and AMNJ)*  
**23**
- 2 Immunology**  
 11 a.m. — Greystone Park Psychiatric Hospital  
*(AMNJ and AAFP)*
- 2 Infectious Disease Course**  
 8:30-9:30 a.m. — Somerset Hospital, Somerville  
*(Somerset Hospital and AAFP)*
- 3 Clinical Immunology**  
 8:30 a.m. — United Hospitals of Newark  
*(AMNJ and AAFP)*
- 3 Psychiatric Lecture Series**



- 10 1:30-5 p.m. — Trenton Psychiatric Hospital  
17 (*Trenton Psychiatric Hospital and AMNJ*)
- 6 **Neuroscience Conferences**  
13 11:30 a.m.-12:30 p.m. — Bergen Pines County Hospital  
20 Paramus  
27 (*Bergen Pines County Hospital and AMNJ*)
- 6 **Obstructive Lung Disease**  
8 p.m. — Community Memorial Hospital, Toms River  
(*AMNJ and AAFP*)
- 7 **Surgical Management of Cushing's Syndrome**  
5-6 p.m. — Rutgers Medical School, Piscataway  
(*Rutgers Medical School and Academy of Medicine*)
- 8 **1977 Update on Traditional and New Venereal Disease**  
1-3 p.m. — Christ Hospital, Jersey City  
(*Christ Hospital, AMNJ, and AAFP*)
- 11 **CME Program**  
25 8-10 a.m. — Newcomb Hospital, Vineland  
(*University of Pennsylvania School of Medicine and AAFP*)
- 14 **Cancer in New Jersey**  
8 p.m. — Paul Kimball Hospital, Lakewood  
(*AMNJ and AAFP*)
- 14 **Medical Care in Emergency Department**  
9 p.m. — Bayonne Hospital  
(*AMNJ and AAFP*)
- 14 **Medical/Legal Aspects of Medicine and Surgery**  
12 noon — Hospital Center at Orange  
(*AMNJ and AAFP*)
- 14 **Dermatologic Surgery**  
8-10 p.m. — Schering Corporation, Kenilworth  
(*New Jersey Dermatological Society and AMNJ*)
- 15 **Hypertension**  
8:30-4:30 — Sheraton Inn, Newark Airport  
(*Pfizer Pharmaceutical, St. Barnabas Medical Center, and AMNJ*)
- 15 **Special Problems in Neurology**  
7-10 p.m. — VA Hospital, East Orange  
(*VA Hospital and AMNJ*)
- 15 **Diagnosis and Management of the Short Child**  
8:30-10 p.m. — 1257 Kensington Road, Teaneck  
(*Bergen Co. Chapter, American Medical Women's Assn. and AMNJ*)
- 15 **Proper Use of Antibiotics**  
1 p.m. — Trenton Psychiatric Hospital  
(*AMNJ and AAFP*)
- 15 **Drug Interactions**  
1-3 p.m. — Christ Hospital, Jersey City  
(*Christ Hospital, AMNJ and AAFP*)
- 16 **Sexual Counseling**  
6:15 p.m. — Bridgeton Hospital  
(*Bridgeton Hospital*)
- 16 **Emotional Management in Myocardial Infarction**  
5-6:30 p.m. — Somerset Hospital, Somerville  
(*Somerset Hospital and AAFP*)
- 17 **The Violent Patient**  
5 p.m. — Holiday Inn-Deepwater  
(*AMNJ and AAFP*)
- 17 **Diagnosis of Anemic Patient**  
12 noon — Freehold Area Hospital  
(*AMNJ and AAFP*)
- Edward Waters Gynecologic Conference**  
17 2-7 p.m. }  
18 8:30 a.m.-7 p.m. } Resorts International  
19 9 a.m.-12:30 p.m. } Hotel, Atlantic City  
(*CMDNJ, NJ Medical School and AMNJ*)
- 18 **Emergency '78—Sports Medicine and Sports Emergencies**  
Ninth Annual Meeting — Valley Hospital, Ridgewood  
(*Valley Hospital*)
- 21 **Scanning**  
12 noon — St. Mary's Hospital, Orange  
(*AMNJ and AAFP*)
- 21 **Congestive Heart Failure**  
8:30 p.m. — Fair Lawn Memorial Hospital—Marriott Saddlebrook  
(*AMNJ and AAFP*)
- 21 **Northern Regional Chest Conferences**  
7:30-9:30 p.m. — St. Joseph's Hospital, Paterson  
(*New Jersey Thoracic Society and AMNJ*)
- 24 **Bleeding Disorders**  
12:30 p.m. — Hamilton Hospital, Trenton  
(*AMNJ and AAFP*)
- 28 **Hepatitis**  
8 p.m. — Warren Hospital, Phillipsburg  
(*AMNJ and AAFP*)
- 29 **Cerebral Vascular Disease**  
3 p.m. — Ancora Psychiatric Hospital, Hammonton  
(*AMNJ and AAFP*)
- 29 **Blood Gases: Revisited**  
1-3 p.m. — Christ Hospital, Jersey City  
(*Christ Hospital and AMNJ*)
- Apr.**
- 3 **Neuroscience Conferences**  
10 11:30 a.m.-12:30 p.m. — Bergen Pines County Hospital,  
17 Paramus  
24 (*Bergen Pines County Hospital and AMNJ*)
- 3 **Suicidology**  
8 p.m. — Community Memorial Hospital, Toms River  
(*AMNJ and AAFP*)
- 4 **New Developments in Scanning**  
11 a.m. — Greystone Park Psychiatric Hospital  
(*AMNJ and AAFP*)

- 5 **Advances in Medicine**  
12 9:30-11 a.m. — Bergen Pines County Hospital, Paramus  
19 (*Bergen Pines County Hospital and AMNJ*)  
26
- 5 **Cardiology Conferences**  
19 4-6 p.m. — Rutgers Medical School, Piscataway  
(*CMDNJ and AMNJ*)
- 5 **Outpatient Management of Tuberculosis**  
11:30 a.m. — Rahway Hospital  
(*AMNJ and AAFP*)
- 5 **Suicidology**  
1 p.m. — Christ Hospital, Jersey City  
(*AMNJ and AAFP*)
- 5 **Courses for Psychiatrists**  
12 8-10 p.m. — Hackensack Hospital  
19 (*NJ Psychoanalytic Society and AMNJ*)  
26
- 5 **Lectures in Obstetrics/Gynecology**  
6-10 p.m. — 141 S. Harrison St., E. Orange  
(*New Jersey Medical School and AMNJ*)
- 6 **Current Concepts in Modern Biology**  
4-6 p.m. — Institute for Medical Research, Camden  
(*Institute for Medical Research and AMNJ*)
- 6 **Care of the Aged Arthritic Patient**  
2-4 p.m. — Daughters of Miriam Center, Clifton  
(*Daughters of Miriam Center for the Aged, AMNJ and AAFP*)
- 6 **Pediatric Allergy Course**  
13 11 a.m.-12 noon — Children's Hospital of Newark  
20 (*Children's Hospital of Newark and AMNJ*)  
27
- 6 **Infectious Disease Course**  
8:30-9:30 a.m. — Somerset Hospital, Somerville  
(*Somerset Hospital and AMNJ*)
- 7 **Infectious Diseases**  
8:30 a.m. — United Hospitals of Newark  
(*AMNJ and AAFP*)
- 7 **Psychiatric Lecture Series**  
14 1:30-5 p.m. — Trenton Psychiatric Hospital  
21 (*Trenton Psychiatric Hospital and AMNJ*)  
28
- 8 **Orthopedic Symposium**  
8 a.m.-4:30 p.m. — Rutgers Medical School, Piscataway  
(*Rutgers Medical School, and AMNJ*)
- 8 **CME Program**  
22 8-10 a.m. — Newcomb Hospital, Vineland  
(*University of Pennsylvania School of Medicine and AAFP*)
- 11 **Fluid and Electrolyte Balance**  
12 noon — Hospital Center at Orange  
(*AMNJ and AAFP*)
- 11 **Connective Tissue Diseases Including Vasculitis**  
8-10 p.m. — Schering Corporation, Kenilworth  
(*New Jersey Dermatological Society and AMNJ*)

- 11 **Complex Problems of the Biliary Tract**  
5-6 p.m. — Rutgers Medical School, Piscataway  
(*Rutgers Medical School, and AMNJ*)
- 12 **Proper Use of Blood Gases**  
1:30 p.m. — John E. Runnells Hospital, Berkeley Heights  
(*AMNJ and AAFP*)
- 12 **Psychiatry**  
17 1-3 p.m. — Ancora Psychiatric Hospital, Hammonton  
19 (*Ancora Psychiatric Hospital and AMNJ*)  
26
- 18 **Northern Regional Chest Conferences**  
7:30-9:30 p.m. — Location to be announced  
(*New Jersey Thoracic Society and AMNJ*)
- 18 **Intra-Aortic Balloon Pumping**  
12 noon — St. Mary's Hospital, Orange  
(*AMNJ and AAFP*)
- 19 **The Psychodynamics of Dental Practice**  
9 a.m.-4 p.m. — New Jersey Dental School, Newark  
(*AMNJ and CMDNJ*)
- 19 **Special Problems in Neurology**  
7-10 p.m. — VA Hospital, East Orange  
(*VA Hospital and AMNJ*)
- 20 **Nevi and Melanoma**  
6:15 p.m. — Bridgeton Hospital  
(*Bridgeton Hospital*)
- 20 **Hypertension — Old and New Concepts**  
5-6:30 — Somerset Hospital, Somerville  
(*Somerset Hospital and AMNJ*)
- 21 **Management of Hepatitis**  
12 noon — Freehold Area Hospital  
(*AMNJ and AAFP*)
- 22 **Seminar in Anesthesiology**  
9 a.m.-3 p.m. — Saint Barnabas Medical Center, Livingston  
(*Educational Council for Anesthesiology of NJ and AMNJ*)
- 25 **Medical/Legal Aspects of Medicine and Surgery**  
8 p.m. — Warren Hospital, Phillipsburg  
(*AMNJ and AAFP*)
- 26 **General Problems in Psychiatry**  
1:15-2:45 p.m. — Marlboro Psychiatric Hospital  
(*Marlboro Psychiatric Hospital and AMNJ*)
- 28 **Surgical Management of Inflammatory Bowel Disease**  
12:30 p.m. — Hamilton Hospital, Trenton  
(*AMNJ and AAFP*)

#### May

- 1 **Neuroscience Conferences**  
8 11:30 a.m.-12:30 p.m. — Bergen Pines County Hospital,  
15 Paramus  
22 (*Bergen Pines County Hospital and AMNJ*)
- 1 **Arthritis**  
8 p.m. — Community Memorial Hospital, Toms River  
(*AMNJ and AAFP*)

- 1 **Psychiatry**  
17 1-3 p.m. — Ancora Psychiatric Hospital, Hammonton  
30 (*Ancora Psychiatric Hospital and AMNJ*)
  - 2 **Thyroid Disease**  
11 a.m. — Greystone Park Psychiatric Hospital  
(*AMNJ and AAFP*)
  - 2 **Feasibility of Breast Cancer Screening**  
5-6 p.m. — Rutgers Medical School, Piscataway  
(*Rutgers Medical School and AMNJ*)
  - 3 **Lectures in Obstetrics/Gynecology**  
6-10 p.m. — 141 S. Harrison St., E. Orange  
(*New Jersey Medical School and AMNJ*)
  - 3 **Advances in Medicine**  
10 9:30-11 a.m. — Bergen Pines County Hospital  
17 Paramus  
24 (*Bergen Pines County Hospital and AMNJ*)
  - 3 **Cardiology Conferences**  
17 4-6 p.m. — Rutgers Medical School  
(*CMDNJ and AMNJ*)
  - 3 **Medical Humanism-Hospital Ethics**  
11:30 a.m. — Rahway Hospital  
(*AMNJ and AAFP*)
  - 3 **Courses for Psychiatrists**  
8-10 p.m. — Hackensack Hospital  
(*NJ Psychoanalytic Society and AMNJ*)
  - 4 **Pediatric Allergy Course**  
11 11 a.m.-12 noon — Children's Hospital of Newark  
18 (*Children's Hospital of Newark and AMNJ*)  
25
  - 4 **Infectious Diseases Course**  
8:30-9:30 a.m. — Somerset Hospital, Somerville  
(*Somerset Hospital of Newark and AMNJ*)
  - 5 **Cerebral Vascular Disease**  
8:30 a.m. — United Hospitals of Newark  
(*AMNJ and AAFP*)
  - 6- **MSNJ Annual Meeting**  
9 Holiday Inn-Howard Johnson's Regency, Atlantic City
  - 9 **Fluid and Electrolyte Imbalance**  
9 p.m. — Bayonne Hospital  
(*AMNJ and AAFP*)
  - 10 **Arthritis**  
1:30 p.m. — John E. Runnells Hospital, Berkeley Heights  
(*AMNJ and AAFP*)
  - 13 **CME Program**  
27 8-10 a.m. — Newcomb Hospital, Vineland  
(*University of Pennsylvania School of Medicine and AAFP*)
  - 15 **Endotoxic/Hemorrhagic Shock**  
12 noon — Hospital Center at Orange  
(*AMNJ and AAFP*)
  - 16 **Kidney Stones**  
12 noon — St. Mary's Hospital, Orange  
(*AMNJ and AAFP*)
  - 17 **Special Problems in Neurology**  
7-10 p.m. — VA Hospital, East Orange  
(*VA Hospital and AMNJ*)
  - 18 **Advances in Pediatrics**  
6:15 p.m. — Bridgeton Hospital  
(*Bridgeton Hospital*)
  - 18 **Antithrombotic Therapy**  
5-6:30 p.m. — Somerset Hospital, Somerville  
(*Somerset Hospital and AMNJ*)
  - 19 **Chronic Renal Failure**  
12 noon — Freehold Area Hospital  
(*AMNJ and AAFP*)
  - 20 **Immunology in Obstetrics and Gynecology**  
9 a.m.-5 p.m. — Governor Morris Inn, Morristown  
(*New Jersey Obstetrical and Gynecological Society and AMNJ*)
  - 23 **Common Topical Agents in Dermatological Practice**  
8:30-10 p.m. — 645 Cambridge Road, Paramus  
(*Bergen Co. Chapter, American Medical Women's Association and AMNJ*)
  - 23 **Cerebral Vascular Disease**  
8 p.m. — Warren Hospital, Phillipsburg  
(*AMNJ and AAFP*)
  - 26 **Ophthalmologic Manifestations in Systemic Disease**  
12:30 p.m. — Hamilton Hospital, Trenton  
(*AMNJ and AAFP*)
  - 31 **Cardiac Arrhythmias**  
3 p.m. — Ancora Psychiatric Hospital, Hammonton  
(*AMNJ and AAFP*)
- June
- 1 **Infectious Disease Course**  
8:30-9:30 a.m. — Somerset Hospital, Somerville  
(*Somerset Hospital and AAFP*)
  - 1 **Current Radiation Therapy**  
11 a.m. — Greystone Park Psychiatric Hospital  
(*AMNJ and AAFP*)
  - 2 **Lipid Metabolism**  
8:30 a.m. — United Hospitals of Newark  
(*AMNJ and AAFP*)
  - 5 **Neuroscience Conferences**  
12 11:30 a.m.-12:30 p.m. — Bergen Pines County Hospital,  
19 Paramus  
26 (*Bergen Pines County Hospital and AMNJ*)
  - 5 **Thyroid Diseases**  
8 p.m. — Community Memorial Hospital, Toms River  
(*AMNJ and AAFP*)
  - 6 **Esophageal Emergencies**  
5-6 p.m. — Rutgers Medical School, Piscataway  
(*Rutgers Medical School and AMNJ*)
  - 7 **Advances in Medicine**  
14 9:30-11 a.m. — Bergen Pines County Hospital, Paramus  
(*Bergen Pines County Hospital and AMNJ*)
  - 7 **Cardiology Conferences**  
21 4-6 p.m. — Rutgers Medical School, Piscataway  
(*CMDNJ and AMNJ*)



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|---|--|
| <p><b>7 Psychiatry</b><br/> <b>14</b> 1-3 p.m. — Ancora Psychiatric Hospital, Hammonton<br/> <i>(Ancora Psychiatric Hospital and AMNJ)</i></p> <p><b>10 Differential Diagnosis — the Wheezing Patient</b><br/> <b>24 The Leukemias</b><br/>             8-10 a.m. — Newcomb Hospital, Vineland<br/> <i>(Newcomb Hospital and University of Pennsylvania Hospital)</i></p> <p><b>15 Beta-Adrenergic Blocking Agent in Cardiovascular Disease</b><br/>             5-6:30 p.m. — Somerset Hospital, Somerville<br/> <i>(Somerset Hospital and AMNJ)</i></p> <p><b>16 Sports Medicine</b><br/>             12 noon — Freehold Area Hospital<br/> <i>(AMNJ and AAFP)</i></p> <p><b>20 Northern Regional Chest Conferences</b><br/>             7:30-9:30 p.m. — Beth Israel Hospital, Newark<br/> <i>(New Jersey Thoracic Society and AMNJ)</i></p> | <p><b>20 Acute and Chronic Leukemia</b><br/>             12 noon — St. Mary's Hospital, Orange<br/> <i>(AMNJ and AAFP)</i></p> <p><b>20 Shock</b><br/>             8:30 p.m. — Fair Lawn Memorial Hospital — Marriott Saddle Brook<br/> <i>(AMNJ and AAFP)</i></p> <p><b>21 Special Problems in Neurology</b><br/>             7-10 p.m. — VA Hospital, East Orange<br/> <i>(VA Hospital and AMNJ)</i></p> <p><b>27 Current Radiation Therapy</b><br/>             8 p.m. — Warren Hospital, Phillipsburg<br/> <i>(AMNJ and AAFP)</i></p> <p><b>30 Chronic Obstructive Lung Disease</b><br/>             12:30 p.m. — Hamilton Hospital, Trenton<br/> <i>(AMNJ and AAFP)</i></p> |
|---|--|

## 212th Annual Meeting — May 6-9, 1978

### Holiday Inn and Howard Johnson's Regency Motor Hotel Atlantic City

House of Delegates  
Golden Merit Award  
Ceremony and Reception

Holiday Inn

Scientific Sessions  
Reference Committees

Holiday Inn/Howard Johnson's

Saturday Evening  
Reception/Dinner  
Inaugural Reception/Dinner  
Dinner Dance

Howard Johnson's

**Note:** Since all major hotels are under reconstruction or alteration, we will be unable to present exhibits. We regret this limitation on our meeting and anticipate resuming exhibits in 1979.

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STIMULANT & VASODILATOR  
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Ascorbic Acid	100 mg.
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Riboflavin	2 mg.
Pyridoxine HCl	3 mg.

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**WARNING:** Overdosage may cause muscle tremor and convulsions.

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# OBITUARIES

## Dr. Marc C. Angelillo

One of Essex County senior members, Marc C. Angelillo, M.D., died on September 23 at his home in Point Pleasant. Born in Italy in 1899, he emigrated to the United States as a child and earned his medical degree from the Long Island College of Medicine in 1924. Dr. Angelillo practiced general medicine and surgery in Newark until retirement in 1969. He had been on the active staff at Presbyterian, Babies, Columbus, and the American Legion Hospitals in Newark, and the Clara Maass Hospital in Belleville. Dr. Angelillo had served in both of the world wars—as an infantryman in World War I, and in the medical department of the Navy during the second World War. In 1974, he was a recipient of MSNJ's Golden Merit Award, indicating fifty years of medical practice.

## Dr. Harold L. Davis

The former chief of the department of pediatrics at St. Francis Hospital in Trenton, Harold L. Davis, M.D., died in that institution on October 12. A native of Trenton, born in 1904, Dr. Davis was graduated from the University of Pennsylvania School of Medicine in 1927 and pursued further studies in pediatrics, becoming board certified in that specialty. In addition to his appointment at St. Francis Hospital, he had been affiliated with Children's and the University of Pennsylvania Hospitals, both in Philadelphia. Dr. Davis was a Fellow of the American Academy of Pediatrics.

## Dr. Samuel Ettinger

Word has just been received of the death on March 26, of Samuel Ettinger, M.D., an emeritus member of our Hudson County component. Born in Halle, Germany in 1897, Dr. Ettinger earned his medical degree from the Medical College of Martin Luther University in Halle in 1922 and took graduate training in Florence, Italy. He emigrated to the United States early in the 1940's and received his New Jersey license in 1944. From that time

until retirement in 1972, he practiced general medicine in Union City and had been affiliated with the North Hudson Hospital in Weehawken. Dr. Ettinger was a 1972 recipient of MSNJ's Golden Merit Award for fifty years of medical practice.

## Dr. Vincent J. Giuseffi, Jr.

Vincent J. Giuseffi, Jr., M.D., a member of our Essex County component, died on September 22 at his home. Graduated from St. Louis University School of Medicine, class of 1950, Dr. Giuseffi went on to take graduate studies in general surgery at the Mayo Clinic and the University of Minnesota. He was on the active staff at St. James Hospital in Newark, East Orange General, and the Hospital Center at Orange. His professional affiliations included membership in the American Society of Abdominal Surgeons. Dr. Giuseffi was only 53 years old at the time of his death.

## Dr. Paul Grossbard

On September 2, Paul Grossbard, M.D., a member of our Passaic County component, died at his home. Born in 1917 in New York City, Dr. Grossbard was graduated from the University of Louisville Medical College, class of 1941, and took graduate training in obstetrics and gynecology at Chicago Lying-In and Cook County Hospitals, becoming board certified in those fields. He was a Fellow of the American College of Surgeons and of the American College of Obstetricians and Gynecologists, and was a member of the American and New Jersey Obstetrical and Gynecological Societies, having served several terms as secretary of the latter. Dr. Grossbard currently was Director of the Department of Obstetrics and Gynecology at Beth Israel Hospital in Passaic.

## Dr. Clarence W. Jaggard

At the untimely age of 52, Clarence W. Jaggard, M.D., a member of our Cumberland County component, died at his home in Huntsville, Alabama, on October 1. A graduate of Temple University School of Medicine, class of 1955, Dr. Jaggard had practiced general medicine in Woodbury for 21 years and was instrumental



in establishing the community mental health center there, of which he was president for 15 years, and, in association with his wife, the alcoholic abuse center which opened in Deptford Township last January. Until closing his practice last April to accept a teaching appointment at the University of Alabama Medical School, Dr. Jaggard had been on the attending staff at the Underwood Hospital in Woodbury.

#### **Dr. A. Walter Murdock, Jr.**

A. Walter Murdock, Jr., M.D., a member of our Sussex County component, died at his home in Sparta on September 12 after a long illness. Born in 1918 and graduated from the Long Island College of Medicine, class of 1944, Dr. Murdock practiced general medicine and pediatrics in Sparta until 1968 when he accepted appointment as emergency room physician at Overlook Hospital in Summit. While in private practice he had been on the attending staff at Newton Memorial Hospital in Newton. During World War II, Dr. Murdock served with the rank of captain in the medical department of the Army of the United States.

#### **Dr. Harrold A. Murray**

On October 14, 1977, Harrold A. Murray, M.D., the 160th President of the Medical Society of New Jersey, died suddenly at home. (See editorial comment, page 1037, this issue.) A native of Newark, born in 1893, Dr. Murray received his education at Seton Hall University and earned his medical degree from Columbia University's College of Physicians and Surgeons in 1920. He pursued graduate work in pediatrics at Mt. Sinai Hospital, New York, becoming board certified in that specialty. He was chief of pediatrics at both St. James and St. Michael's Hospitals in Newark and ultimately was named medical director of the latter institution. In addition, Dr. Murray was consulting pediatrician to eight other hospitals in the area. In 1960 he was appointed Medical Coordinator at All Souls Hospital, Morristown. He was affiliated with many civic groups relating to children and family health services, both statewide and in his home community.

Dr. Murray long had been active in organized medicine, from committee work in his county medical society (Essex) to president of that body. On the state level he was, for many years, chairman of the Committee on Child Health and of the Committee on Annual Meeting, and in 1949 was elected Second Vice-President, the first of the presidential offices. Dr. Murray's professional affiliations included Fellowship in the American Academy of Pediatrics and District Chairman of that organization for New Jersey, Fellowship in the American College of Physicians, and membership in the Academy of Medicine of New Jersey.

#### **Dr. Johannes F. Pessel**

One of Mercer County's senior members, Johannes F. Pessel, M.D., died on October 14, at his home in Yardley, Pennsylvania. A native of Illinois, Dr. Pessel earned his medical degree from Washington University in St. Louis in 1918 and went on to take residencies in internal medicine and gastroenterology at Johns Hopkins University Medical School, becoming board certified in those specialties. He then served a tour of duty with the United States Public Health Service at Fort McHenry Army Hospital as chief of pathology. In 1929 Dr. Pessel came to Trenton to establish a private practice which he maintained for 45 years. He had been medical director, chief of staff, and director of the department of medicine at Mercer Medical Center and also associate professor of gastroenterology at the Graduate School of Medicine of the University of Pennsylvania. Dr. Pessel was a Fellow of the American College of Physicians and a member of the American Society of Internal Medicine, the American Gastroenterological Association, and the Academy of Medicine of New Jersey. He was 83 years old at the time of his death.

#### **Dr. Morton D. Ritter**

On October 3, Morton David Ritter, M.D., died in Atlantic City Medical Center, where he had headed the department of radiology from 1949 until retirement in 1972. Born in Philadelphia in 1913 and graduated from the Washington University Medical School in 1939, Dr. Ritter pursued a career in radiology, becoming

board certified in that field. In addition to his appointment at Atlantic City Medical Center, he had been on the staff at the Shore Memorial Hospital in Somers Point. Dr. Ritter was a member of the American College of Radiology and the Radiological Society of North America.

#### Dr. George Urbach

We have just learned of the death on August 18 of George Urbach, M.D., in St. Barnabas Medical Center, Livingston, after a long illness. Born in 1908, Dr. Urbach was graduated from Columbia University's College of Physicians and Surgeons in 1933, and practiced general medicine in Newark and South Orange until his retirement because of ill health in 1975. Dr. Urbach had had staff appointments at Clara Maass Memorial Hospital in Belleville, Newark Beth Israel Medical Center, and St. Barnabas Medical Center in Livingston.

#### Dr. Edmond A. Utkewicz

One of Hudson County's senior members, Edmond A. Utkewicz, M.D., died on September 23. Graduated from Long Island University College of Medicine, class of 1934, Dr. Utkewicz practiced family medicine in Jersey City for many years and had been

affiliated with the St. Francis and Margaret Hague Hospitals there. During World War II, he had served for four years with the medical department of the United States Navy.

#### Dr. George L. Wolcott

George Linton Wolcott, M.D., a member of our Morris County component, died on September 4 at his home in Franklin Lakes. Born in 1913 and graduated from Columbia University College of Physicians and Surgeons in 1938, Dr. Wolcott practiced industrial medicine and pursued pharmaceutical research in New York City for twenty years, before accepting a full-time appointment as Scientific Director for Wallace Laboratories in 1959 and transferring his membership to the Medical Society of New Jersey. In 1964 he was named medical director of American Cyanamid's consumer products development group. Dr. Wolcott was a member of the American Academy of Dermatology, American Association for Advancement of Science, American Society for Clinical Pharmacology and Therapeutics, Drug Information Association, New York Academy of Sciences, Society of Cosmetic Chemists, Society for Investigative Dermatology, and was a Fellow of the New York Academy of Medicine. He was the author of several published articles on pharmacology research.

## BOOK REVIEW

**Current Surgical Diagnosis and Treatment.** Third Edition. J. Englebert Dunphy, M.D. and Lawrence W. Way, M.D., Las Altas, California, Lange. 1977. Pp 1139. Illus. (\$18).

A book on the whole of current surgical practice is an ambitious undertaking in view of the complexity of both diagnosis and treatment in present-day surgery. Indeed, one wonders whether such a task can be concluded successfully. This particular book does not provide a positive answer to such speculation, but is a readable attempt to do so.

All of its chapters live up to its authors' prefatory promise to provide basic information in a concise form. Furthermore, at the conclusion of each section, there are references to the literature for those interested in pursuing the matter further. This is a nice touch that other authors of this type of manual should be encouraged to emulate.

As in all such encyclopedic efforts, there are good and bad chapters. The one on the treatment of multiple system injuries, for instance, seems outdated and the illustrations poor. Particularly striking is the advocacy of needle insertion as a means of providing an airway in an emergency. The references are inadequate. There are several completely rewritten chapters. The one on thyroid and parathyroid is particularly good and the one on surgical nutrition also is done well.

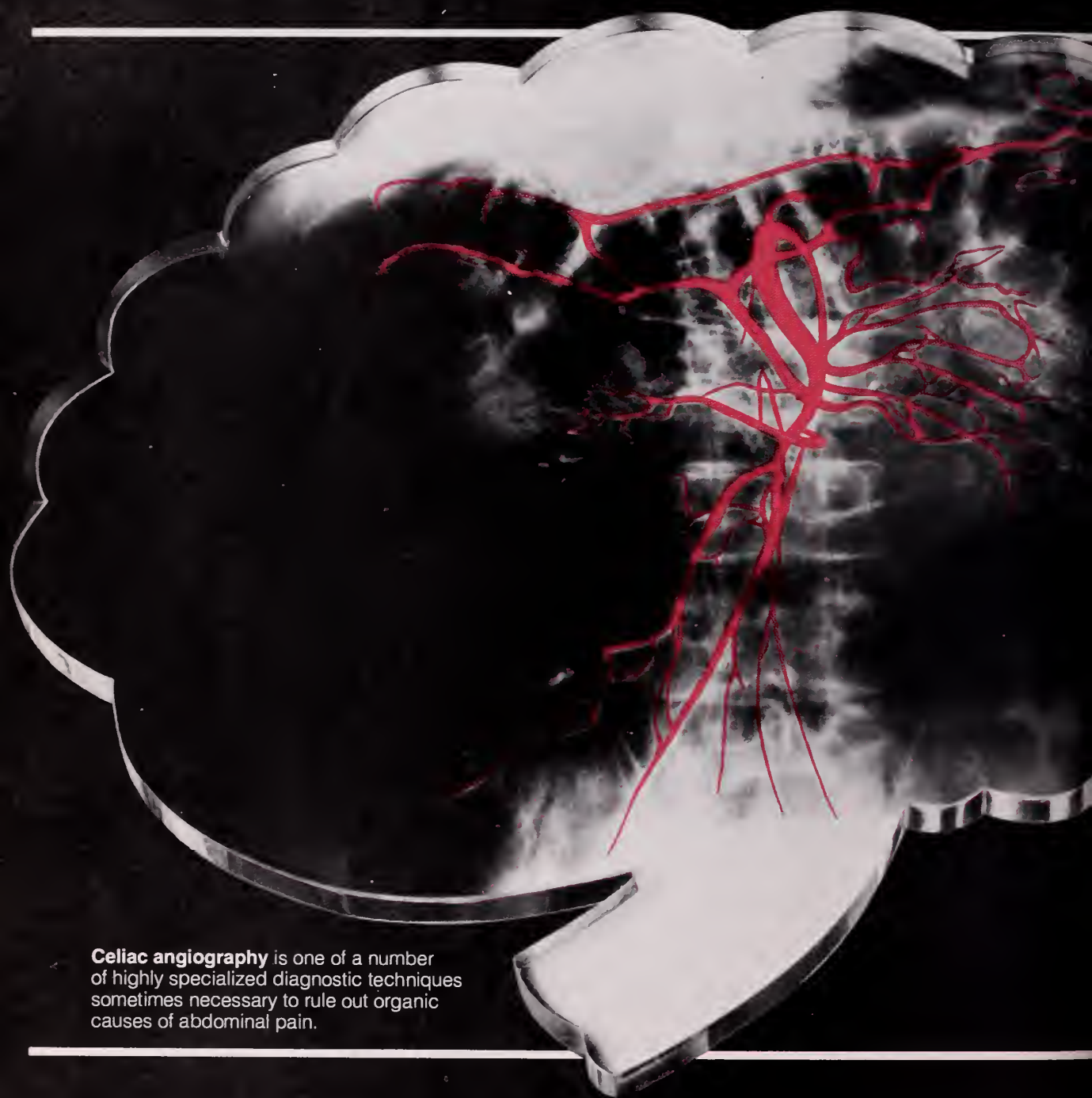
In general, the illustrations are not as good as the text and in some instances are confusing. Despite this drawback, the general format of the book has been well thought out and a very satisfactory index makes it easy for the reader to locate information.

As an attempt to provide a complete encyclopedia of basic information on current surgical practice, the book falls short of its goal. Its most notable lack is the omission of a chapter on immunology. It also contains dogmatic statements which actually are unsettled in current surgical practice. Nevertheless, it does present a great deal of basic surgical information.

William A. Dwyer, Jr., M.D.

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Final classification of the less-than-effective indications requires further investigation.

**Contraindications:** Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide hydrochloride and/or clidinium bromide.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium® (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

**Usage in Pregnancy:** Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

**Precautions:** In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially, increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacologic effects of agents, particularly potentiating drugs such as MAO inhibitors and

phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

**Adverse Reactions:** No side effects or manifestations not seen with either compound alone have been reported with Librax. When chlordiazepoxide hydrochloride is used alone, drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are avoidable in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, i.e., dryness of the mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

**Dosage:** Individualize for maximum beneficial effects. Usual maintenance dose is 1 or 2 capsules, 3 or 4 times a day, before meals and at bedtime. Geriatric patients—see Precautions.

**How Supplied:** Librax is available in green capsules, each containing 5 mg chlordiazepoxide hydrochloride (Librium®) and 2.5 mg clidinium bromide (Quarzan®)—bottles of 100 and 500; Tel-E-Dose packages of 100; Prescription Paks of 50, available singly and in trays of 10.

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creasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

**Adverse Reactions:** Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at

the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

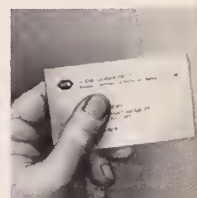
**Usual Daily Dosage:** Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. *Geriatric patients:* 5 mg b.i.d. to q.i.d. (See Precautions.)

**Supplied:** Librium® (chlordiazepoxide HCl) Capsules, 5 mg, 10 mg and 25 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Libritabs® (chlordiazepoxide) Tablets, 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.



Roche Laboratories  
Division of Hoffmann-La Roche Inc.  
Nutley, New Jersey 07110

Please see following page.



Before prescribing, please consult complete product information, a summary of which follows:

**Indications:** Relief of anxiety and tension occurring alone or accompanying various disease states.

**Contraindications:** Patients with known hypersensitivity to the drug.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

**Usage in Pregnancy:** Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

**Precautions:** In the elderly and debilitated and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, in-



# **LIBRIUM<sup>®</sup>** **chlordiazepoxide HCl/Roche** **THE ANXIETY-SPECIFIC**

## **SAFETY**

Seldom associated with  
serious side effects

## **PREDICTABILITY**

An extensive pattern of  
favorable patient response

## **PERFORMANCE**

Proven effectiveness within  
a wide safety margin

## **CONCOMITANT USE**

Little or no interference with  
many primary medications

## **EXPERIENCE**

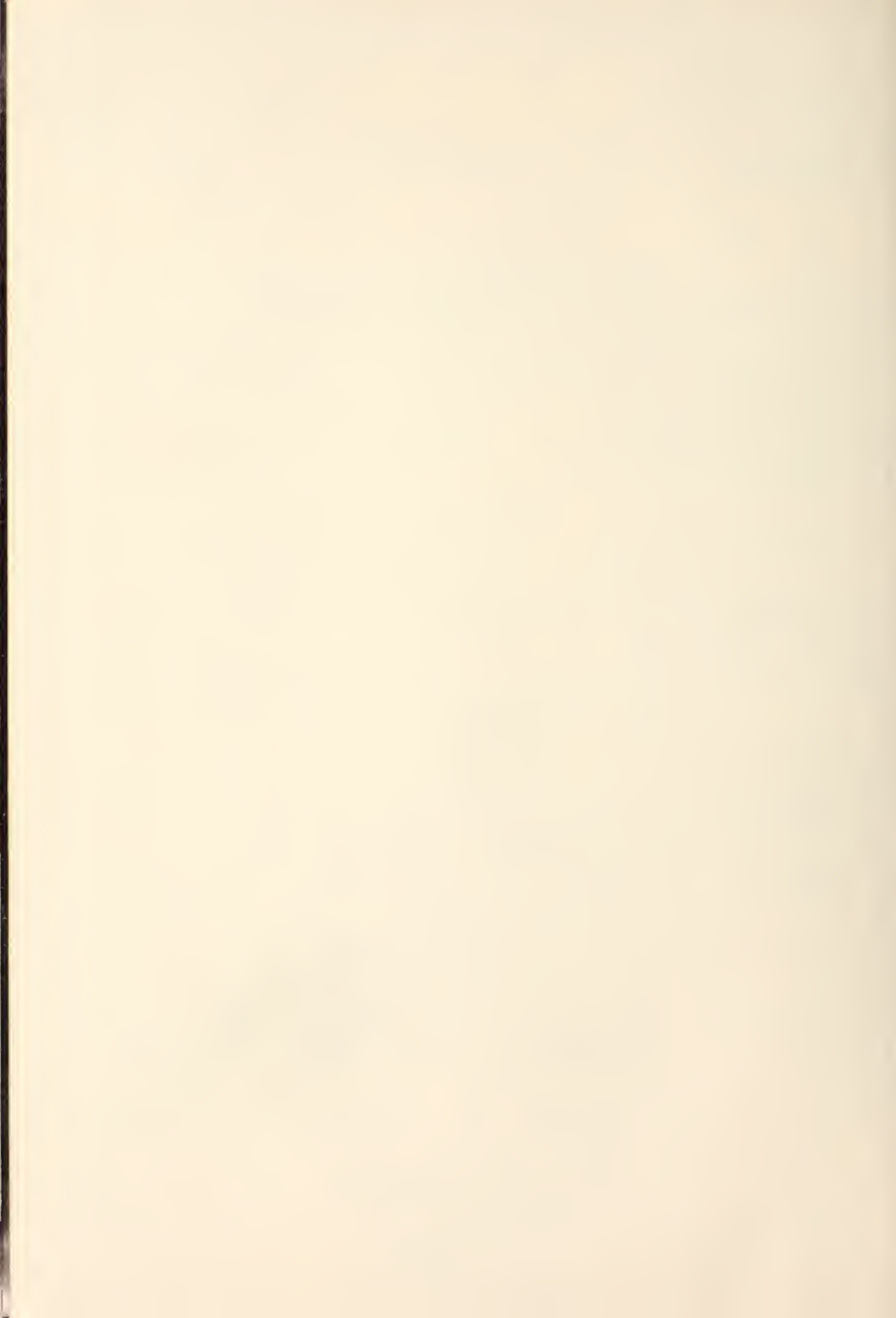
More than a decade and a  
half of effective clinical use

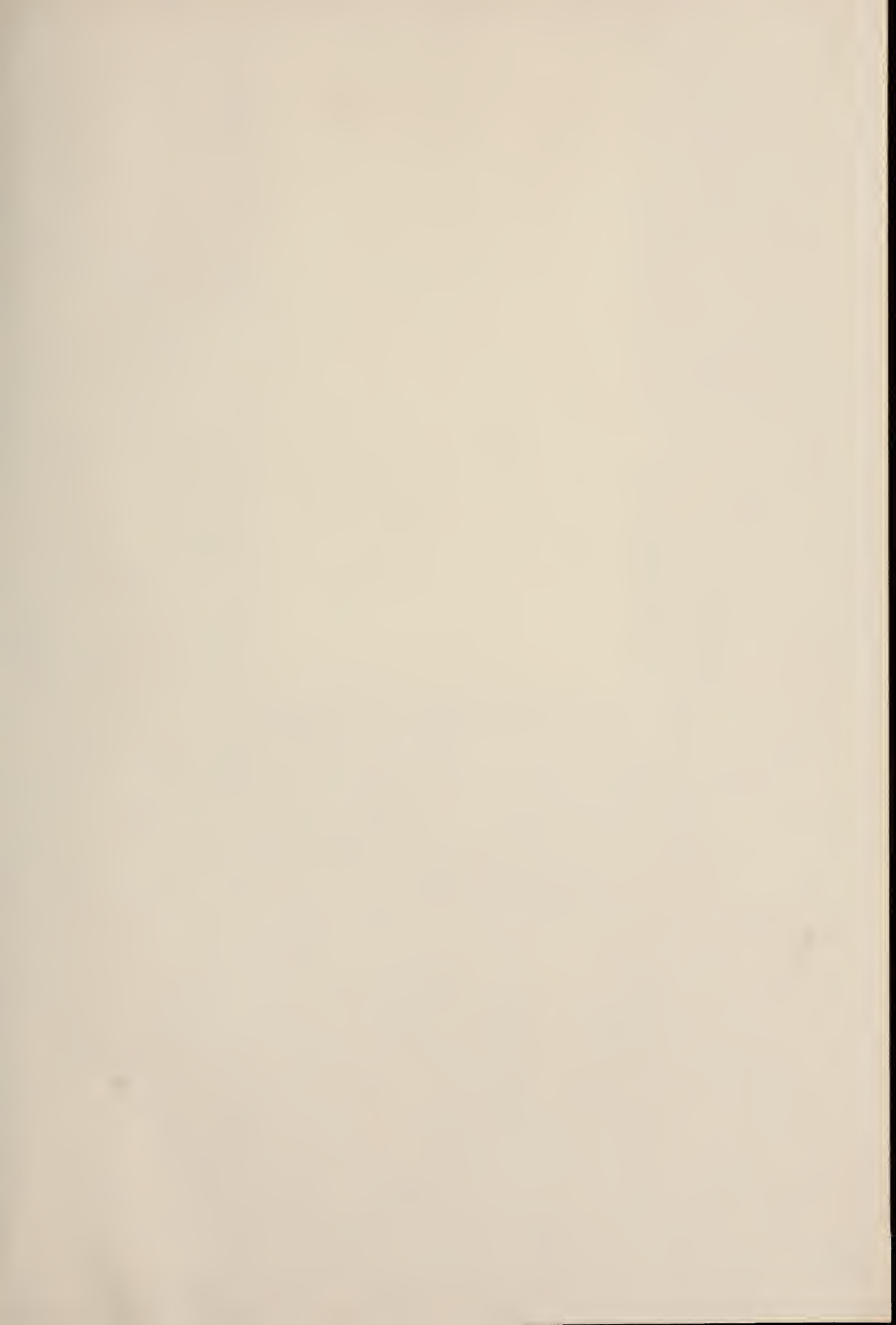


Please see  
preceding page  
for a summary  
of product  
information.











*The New York Academy of Medicine*

**DUE IN 4 WEEKS UNLESS RENEWED**  
**NOT RENEWABLE AFTER 8 WEEKS**

[illegible]

NEW YORK ACADEMY OF MEDICINE



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